S. Hrg. 100-169, Pt. 1

CATASTROPHIC HEALTH INSURANCE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

JANUARY 28, 1987

Printed for the use of the Committee on Finance

Part 1 of 3

U.S. GOVERNMENT PRINTING OFFICE
71-800 WASHINGTON : 1987

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S361-6

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CATASTROPHIC HEALTH INSURANCE

WEDNESDAY, JANUARY 28, 1987

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The Committee met, pursuant to notice, at 10:14 a.m. in Room SD 215, Dirksen Senate Office Building, the Honorable Lloyd Bentsen (chairman) presiding.

Present: Senators Bentsen, Moynihan, Baucus, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Packwood, Danforth, Chafee, Heinz, Wallop, and Durenberger.

[The press release announcing the hearing and the prepared written statements of Senators Bentsen, Mitchell, Pryor, Rockefeller, Dole, Chafee, Heinz, Durenberger and a background paper by the Joint Committee on Taxation follow:]

[Press Release No. H-3, Jan. 21, 1987]

CHAIRMAN BENTSEN ANNOUNCES THE FIRST IN A SERIES OF HEARINGS ON CATASTROPHIC HEALTH INSURANCE

WASHINGTON, DC.—The Honorable Lloyd Bentsen (D., Texas), Chairman, announced today that the Senate Finance Committee will hold a hearing on Wednesday, January 28, 1987 on catastrophic health insurance.

The witness for the hearing will be The Honorable Otis Bowen, M.D., Secretary of Health and Human Services.

"In recent years, rising costs of health care have highlighted the need to improve protection against the costs associated with catastrophic illness," Chairman Bentsen said.

"This hearing is the first in a series the Finance Committee will hold to determine how the private sector and Government can work together to lend support to the elderly and their families when catastrophic illness threatens financial ruin."

Chairman Bentsen stated that the purpose of the hearing will be to examine the issue of coverage of catastrophic illness expenses, including any proposal which the President may make in his State of the Union address on January 27, 1987, and the proposals made by Secretary Bowen in his report to the President in November, 1986.

The hearing will begin at 10:00 A.M. on Wednesday, January 28, 1987 in Room SD-215 of the Dirksen Senate Office Building.

OPENING STATEMENT
CHAIRMAN LLOYD BENTSEN
CATASTROPHIC HEALTH INSURANCE
HEARING

MR. SECRETARY, WE ARE HONORED TO HAVE YOU WITH US THIS MORNING AS WE UNDERTAKE THE FIRST IN A SERIES OF HEARINGS ON THE QUESTION OF HOW THE PRIVATE SECTOR AND GOVERNMENT MIGHT COOPERATE TO IMPROVE PROTECTION FOR VULNERABLE AMERICANS WHEN CATASTROPHIC ILLNESS STRIKES.

AS WE ALL KNOW, THE NUMBERS OF INDIVIDUALS WHO ACTUALLY EXPERIENCE A FINANCIALLY DEVASTATING MEDICAL EVENT IS SMALL -- BUT THAT IS LITTLE CONSOLATION TO THE AFFECTED FAMILIES.

DR. BOWEN, YOU ARE TO BE COMMENDED FOR YOUR LEADERSHIP IN BRINGING THIS ISSUE TO THE ATTENTION OF THE COUNTRY, AND FOR YOUR PERSEVERANCE IN DEVELOPING A SET OF RECOMMENDATIONS THAT WILL RECEIVE THE COMMITTEE'S CLOSE ATTENTION OVER THE COMING MONTHS.

LIKE YOU, MR. SECRETARY, MANY OF US HERE TODAY HAVE A LONG HISTORY OF INTEREST IN THIS ISSUE. YOU MAY RECALL THAT THE FINANCE COMMITTEE HELD EXTENSIVE HEARINGS IN 1978 AND 1979, AND THAT SEVERAL PROPOSALS TO ADDRESS THE FINANCIAL PROBLEMS ASSOCIATED WITH CATASTROPHIC ILLNESS WERE DEVELOPED AT THAT TIME. SENATORS LONG, DOLE, DANFORTH, BAUCUS, AND OTHERS OFFERED A BROAD RANGE OF OPTIONS FOR THE COMMITTEE'S CONSIDERATION.

IN THE LAST CONGRESS, BOTH SENATOR DURENBERGER AND I REVISITED THE ISSUE -- MY BILL, AS YOU MAY KNOW, FOCUSED

ON THE NEED TO CLOSE A NUMBER OF SERIOUS GAPS IN COVERAGE FOR THOSE ELDERLY AND DISABLED INDIVIDUALS WHO PARTICIPATE IN THE MEDICARE PROGRAM.

WITH HIS CHARGE TO YOU LAST EVENING IN HIS STATE OF THE UNION ADDRESS, PRESIDENT REAGAN JOINED IN WHAT I HOPE WILL BE A SUCCESSFUL EFFORT TO BRING TOGETHER THE BEST ELEMENTS OF EACH OF THESE PROPOSALS IN A BIPARTISAN ASSAULT ON THE THREAT OF FINANCIAL RUIN FOR FAMILIES WHO -- THROUGH NO FAULT OF THEIR OWN -- EXPERIENCE A MEDICAL CATASTROPHE.

NOW, I AM WELL AWARE THAT OURS IS NOT AN EASY TASK. WHILE WE BEGIN WITH BROADBASED ENTHUSIASM AND A COMMON GOAL, CONSENSUS DOES NOT YET EXIST WITH RESPECT TO SUCH BASIC ISSUES AS THE SCOPE OF COVERED BENEFITS, TARGET POPULATIONS, OR FINANCING. WE FACE AN ENORMOUS CHALLENGE IN ATTEMPTING TO JOIN DISPARATE VIEWS ON EACH OF THESE ISSUES -- BUT FACE IT WE MUST. THE AMERICAN PEOPLE EXPECT, AND DESERVE, NOTHING LESS THAN OUR BEST EFFORT TO CONSTRUCT A GENUINE "SAFETY NET" FOR THOSE FEW SITUATIONS WHEN EXISTING PRIVATE AND PUBLIC INSURANCE IS NOT ENOUGH.

WHILE I REMAIN OPEN TO SUGGESTIONS ABOUT THE ELEMENTS OF A COMMITTEE BILL -- OR SERIES OF BILLS -- I BELIEVE AGREEMENT MAY BE WITHIN OUR REACH WITH RESPECT TO CLOSING GAPS IN COVERAGE FOR THE ELDERLY AND DISABLED WHO NOW RELY ON MEDICARE AS THEIR PRINCIPAL SOURCE OF HEALTH INSURANCE.

MORE THAN 28 MILLION ELDERLY PEOPLE ARE COVERED BY MEDICARE TODAY. LAST YEAR, 21 MILLION PAID $13 BILLION IN PREMIUMS FOR PRIVATE SUPPLEMENTARY INSURANCE. YET 20 PERCENT

REMAIN UNCOVERED BY MEDICAID OR PRIVATE MEDIGAP POLICIES. ACCORDING TO ACTUARIES WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, LACK OF SUPPLEMENTAL INSURANCE MEANS THAT, WHILE MOST OLDER AMERICANS HAVE SOME FORM OF THIRD PARTY COVERAGE, FULLY ONE-FIFTH OF THOSE OVER THE AGE OF 65 ARE AT RISK OF A FINANCIAL CATASTROPHE. WITH HEALTH CARE COSTS RISING AT A RATE OF 7.7 PERCENT IN 1986 -- SEVEN TIMES THE INCREASE IN THE SOCIAL SECURITY COST OF LIVING ADJUSTMENT -- IT IS CLEAR THAT WE MUST MOVE AHEAD TO BUILD NEEDED PROTECTIONS INTO THE CURRENT SYSTEM.

AS THE COMMITTEE BEGINS ITS DELIBERATIONS, I HOPE MEMBERS WILL CONCUR THAT OUR WORK SHOULD BE GUIDED BY A HANDFUL OF BASIC OBJECTIVES:

--- ADDITIONAL COVERAGE SHOULD BE PROVIDED FOR PERSONS WHO REQUIRE LENGTHY HOSPITALIZATION;

--- PERVERSE ARRANGEMENTS THAT PLACE THE GREATEST FINANCIAL LIABILITY ON THE SICKEST PATIENTS MUST BE REFORMED;

--- SKILLED NURSING CARE AND COMMUNITY BASED SERVICES MUST BE PROVIDED FOR THOSE WHO REQUIRE TRANSITION CARE BETWEEN HOSPITAL AND HOME;

--- RESTRAINTS ON OUT-OF-POCKET EXPENSES SHOULD PROTECT THE MOST SERIOUSLY ILL WHOSE LIFE SAVINGS WOULD BE QUICKLY EXHAUSTED BY AN UNEXPECTED MEDICAL CATASTROPHE; AND

--- THESE IMPROVEMENTS SHOULD BE FINANCED USING THE BROADEST POSSIBLE BASE AND MUST NOT EXACERBATE AN ALREADY SERIOUS FEDERAL DEFICIT.

MR. SECRETARY, YOUR GUIDANCE AND EXPERTISE ARE CRITICAL TO THE SUCCESS OF THIS UNDERTAKING. I LOOK FORWARD TO HEARING YOUR TESTIMONY TODAY AND TO WORKING WITH YOU OVER THE NEXT FEW MONTHS TO DEVELOP A LEGISLATIVE PACKAGE THAT, WHEN SIGNED INTO LAW, WILL HELP TO PROTECT THE MOST VULNERABLE AMONG US FROM FINANCIAL RUIN THAT CAN ACCOMPANY A CATASTROPHIC ILLNESS.

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STATEMENT

SENATOR GEORGE J. MITCHELL

SENATE COMMITTEE ON FINANCE

JANUARY 28, 1987

As the new Chairman of the Health Subcommittee of the Senate Finance Committee, I take special interest in this opportunity to examine the problem of catastrophic health care expenses. I am pleased that Secretary Bowen has responded in such a thorough and thoughtful manner to the challenge that was presented to him. He has articulated the need for public as well as private initiatives in addressing the problems posed by acute catastrophic health care expenses. His doing so, in the face of strong opposition by some in the administration, is commendable. However I am concerned with the Secretary's very limited response to the issue of long term care costs.

While the Congress and the Administration must both continue to be concerned with the current Federal deficit, we cannot allow those concerns to overshadow the responsibilities that the Federal government has assumed in the area of health care.

Catastrophic health care expenses occur at a time that the individual is usually suffering from a major debilitating illness. Just at the time the individual, and often their spouse and other family members are trying to adjust to the effects of a serious illness, their problems are compounded by another crisis-that of high out of pocket expenses for health care.

In many younger persons the lack of insurance coverage for such illness is a result of unemployment or even more frequently employment in a low-paying job in an industry where employers are unable, or unwilling to provided such coverage. Private insurance firms, the states and the federal government must work in concert to provide insurance coverage for these individuals.

While the vast majority of our older citizens have some insurance in the form of Medicare, they still face out of pocket expenses that are higher than the average for most other groups. The structure of Medicare benefits for acute hospital care and for physician services, and the lack of coverage for out-patient medications are all sources of acute catastrophic expenses for the elderly.

Especially problematic in this respect is the large copayment required from Medicare beneficiaries with prolonged hospital stays. Such a copayment does nothing to hold down utilization and results in a major financial burden on the unfortunate few that experience such a severe prolonged illness.

The aggregate cost of these acute care catastrophic expenses represent a significant but not overwhelming problem. The burden of these costs at present falls on those who can least afford them-those older persons with multiple exacerbations of chronic illness or those with complex, severe acute diseases. We need to move towards the implementation of a system that will eliminate the unecessary stress of excessivly high out-of-pocket acute care expenses on such individuals.

The problems presented by long term care costs, which account for over 80% of the catastrophic expenses of those over 65, are very large and very complex. Expenses for long term care already exceed $30 billion dollars a year. Over half the of the costs of long term care at present are paid directly by the elderly and their families. Contrary to the beliefs of much of the public, Medicare coverage for long term care, and especially nursing home care, is minimal. Private insurance, while offering some promise, currently accounts for less than 2% of the costs of long term care.

The lack of an appropriate means of financing long term care has turned the Medicaid program, which was intended as a means tested health care program for the indigent, into the primary public long term care program. The use of this program for financing long term care for the elderly has resulted in the impoverishment of many elderly persons and in some cases their families as well. This problem reaches it greatest absurity when spouses of those who require nursing home care are forced to decide between giving up their homes or divorcing their spouses for financial reasons.

Adding to our concern is the certainity that the demographics of our population will result in a doubling of the need for long term in the next twenty-five years, and a quadrupling by the year 2040. While innovations in the delivery of home health services can offer a wider choice to older individuals, recent evidence suggests that they will not be a panacea for reducing long term care costs.

The need to address the problem of long term care is clear. Equally clear, given the enormous financial and personal burdens imposed by the cost of long term care, is the necessity to proceed carefully and cautiously in our efforts to manage this problem

Our goal must be to find ways to insure a system of financing long term care that is equitible, avoids incentives that favor institutional care over home care, enhances choice and preservation of the family and is cost effective. This will be a major task but one which we must pursue.

OPENING STATEMENT
THE HONORABLE DAVID PRYOR
at a hearing on
CATASTROPHIC HEALTH CARE COSTS

Wednesday, January 28, 1987 Room 215 Dirksen Senate
10:00 a.m. Office Building

Mr. Chairman, I'd like to congratulate you on the scheduling of this hearing. Catastrophic coverage seems to be the issue of the hour -- the newspapers are filled with articles on it, and this week alone several Congressional committees have scheduled hearings on the topic. This is a significant change since last August when I held a field hearing on this topic in Arkansas, and found limited hearing reference to the issue during recent Congresses. I hope that this increased attention will translate into some positive legislative action this year.

It is no secret that HHS Secretary Otis Bowen is to be credited for a great deal of the attention being focused in the area of catastrophic health care costs. Although through the years there have been a number of legislative proposals submitted to deal with one or more aspect of the catastrophic problem (including an acute catastrophic plan proposed by you, Mr. Chairman), the Secretary's endorsement of a catastrophic plan and subsequent Advisory Committee meetings started many of the interested parties talking. Equal in importance, however, is the definition for "catastrophic" that the Secretary's Advisory Committee came up with -- a disease or condition was defined as catastrophic based on its financial impact upon an individual or a family. This is a much broader approach than had been previously taken, one which includes three distinct problem areas: acute catastrophic care for the elderly, long-term health care coverage for the elderly; and long-term and catastrophic health care coverage for individuals of all ages. I believe the Congress must retain this broad approach in order to make any significant inroads in dealing with this problem.

ACUTE CATASTROPHIC CARE FOR THE ELDERLY

The first of these areas -- acute catastrophic coverage for the elderly -- is the area which can be most readily addressed. The major options include:

-- Improvements to current national Medigap policy and more stringent enforcement of laws regarding these policies; and/or

-- Expansion of the Medicare program to fill the most glaring acute care gaps.

The latter is part of Secretary Bowen's plan. The relative ease with which this problem can be addressed does not imply a lack of importance -- the gaps in acute care coverage have been serious problems since Medicare's inception which can financially devastate an elderly individual or couple. In fact, that has been exactly what has happened to around 5 percent of the

Medicare population, and the other 95 percent live in fear of that occurring.

ACUTE/MINIMUM COVERAGE FOR ALL AGE GROUPS

The elderly have no monopoly on health care needs or expenses. A major problem this nation must face is that of uncovered care -- individuals and families who have no health insurance coverage whatsoever. Around 18 percent (35 million) of the under 65 population have no health care coverage. We must work to create greater incentives for participation in group health insurance programs and to make federal programs more responsive to these needs. I am hopeful that the Subcommittee on Private Retirement Plans and Oversight of the IRS will be actively involved in creating incentives for broader employer-sponsored health care coverage and prefunding of retiree health benefits.

LONG TERM CARE FOR THE ELDERLY

Finally, the area of long term care coverage for the elderly must be examined. There are a number of changes which are needed to clarify benefits in this area -- particularly in the home health and Medicare nursing home benefit areas. We must also fully examine the concept of long term care and nursing home insurance. There are some serious concerns about the wisdom of marketing long term care policies on a large scale -- particularly about the funding of such an expensive product.

Frequently I hear of elderly couples who both have serious health problems -- where one must sacrifice attention to his or her own health care needs in order to finance care for the other. This type of situation is unconscionable, and we have an obligation to address it. The area of spousal impoverishment has not received sufficient attention. This occurs when one member of an elderly couple is placed in a nursing home or needs other expensive health care and the community property is liquidated in order to pay for the necessary care, leaving the spouse in the community destitute. We need to find a workable way to limit liability in situations like these.

Mr. Chairman, I know that there is much that can be done, and I plan to be actively involved in the debate on the issue. The implementation of a truly comprehensive national catastrophic plan may take a number of years, but the prospects are more hopeful now than ever before to accomplish some meaningful reform in this area. I stand ready to work with my colleagues toward that goal.

STATEMENT BY
SENATOR JOHN D. ROCKEFELLER IV

FINANCE COMMITTEE HEARING ON CATASTROPHIC HEALTH INSURANCE
January 28, 1987

I am sure that I share with my distinguished colleagues intense interest in Secretary Bowen's testimony. The Secretary's report of late last year to the President on catastrophic illness expenses has given us -- and the American people -- cause to believe that the time has arrived when Congress and the Administration can work out some form of a solution to this enormous problem. It's my hope that today's hearing will launch such an effort.

I'm concerned, however, by the conflicting signals we have been receiving from the Administration on health care. Secretary Bowen properly has received a great deal of praise for his November report on the catastrophic crisis. This document presents a range of options to improve and expand coverage for the elderly and the rest of Americans who, because of being either underinsured or uninsured, are at risk of staggering health care costs. While I have questions or concerns about some of the specific ideas proposed, I applaud the Secretary for taking this major step to lay out possible ways of tackling this problem.

But then, as soon as the report -- and it was a report, not legislation carved in stone -- was released, other Administration officials actually trounced it in public. The President's Chairman of Economic Advisors was especially verbose, charging that aspects of the Bowen plan "would replace a competitive private market with a Government monopoly."

I don't think these charges were fair or helpful to the debate on the catastrophic issue. For twenty years, Medicare has been the primary source of health insurance for a substantial portion of America's elderly population. Seeing that many thousands of senior citizens are incurring staggering personal expenses every year because of the gaps in Medicare, Congress has to consider whether the program can and should be expanded -- and we must look into other options, some suggested by Secretary Bowen, for spurring more affordable and more widely available catastrophic coverage by the private sector.

Another deeply disturbing message about health care recently came in the form of President Reagan's fiscal year 1988 budget. The budget for the Department of Health and Human Services proposes $6.6 billion in cuts from Medicare and Medicaid in FY88 and a total of $61.5 billion over the next five years. One of HHS's specific suggestions for achieving these "savings" is to significantly increase the Medicare Part B premium for new retirees. I find $6.6 billion of reductions in health care unconscionable. This committee will be taking up the budget on a different day, but I do raise it now to say this: there's a serious conflict between the Secretary's initial and welcome expression of support for broadening Medicare to cover more of catastrophic expenses and the budget we just received which is totally silent on catastrophic care but full of proposals to cut services and increase beneficiary costs.

I'm anxious, therefore, to learn more about Secretary Bowen's -- and President Reagan's -- thinking about how we might pursue this serious problem. In contemplating possible solutions, I have a number of goals which I hope will be achieved.

First and foremost, we can't let this crisis go on. We must find ways to protect seniors and the rest of the population from medical bills that wipe them out financially.

Second, let's urge the private sector to work with us fully. Recently, some of the private insurers have been critical of the Medicare- and government-related proposals which have emerged. I certainly hope there are steps that can be taken to foster better catastrophic coverage in the private sector. If it can be offered, what will it take to see it developed soon? The existing Medigap policies are clearly not enough -- in fact, many beneficiaries mistakenly believe these private policies protect them from catastrophic medical costs.

Next, a more specific objective of mine is to truly make home health care an option for individuals requiring continual personal or medical care. In West Virginia, it's strongly believed that many of the elderly who enter nursing homes by qualifying for Medicaid could receive the care they need at home instead. We know that home health care is less expensive in most cases than nursing home or hospital care. In addition to creating a more humane form of care for many people, making this option available should free up funds to expand the population served by Medicare and Medicaid.

I also want to explore how the tragedy of "spousal impoverishment" can be avoided. We just learned about the Massachusetts study showing that the spouses of one third of the elderly entering nursing homes under Medicaid had to deplete their bank accounts and assets of practically all they owned. This is inhumane.

Finally, I think the American people expect us to address the catastrophic health care problem in the broadest sense. This means considering ways to insure citizens for longer hospitalization stays, long-term care, and other highly costly medical expenses.

The American people, however, don't want Congress to make promises that can't be kept. The budget deficit is no secret -- we should only take those steps which we know we can afford.

I am anxious to begin this effort and ease the catastrophic crisis burdening so many of our citizens.

SENATOR BOB DOLE

CATASTROPHIC HEALTH INSURANCE

I WANT TO THANK THE DISTINGUISHED CHAIRMAN OF THE SENATE FINANCE COMMITTEE FOR HOLDING THIS HEARING ON CATASTROPHIC HEALTH INSURANCE. AND I ESPECIALLY WANT TO WELCOME SECRETARY BOWEN. I AM LOOKING FORWARD TC THIS OPPORTUNITY TO EXPLORE WITH THE SECRETARY HIS EXPERIENCE IN WORKING WITH THE CATASTROPHIC HEALTH INSURANCE ADVISORY GROUP OVER THE PAST YEAR.

DOLE/DANFORTH/DOMINICI 1979

FOR MANY OF US ON THIS COMMITTEE, THE SUBJECT OF CATASTROPHIC HEALTH INSURANCE PRESENTS US WITH AN OPPORTUNITY TO LEARN FROM OUR OWN PAST. I INTRODUCED MY FIRST CATASTROPHIC HEALTH INSURANCE BILL WITH SENATOR DANFORTH AND SENATOR DOMINICI IN 1979 (THE SO-CALLED "TRIPLE D" BILL). THAT BILL CONSISTED OF THE FOLLOWING: FIRST, THOSE ELIGIBLE FOR MEDICARE WERE TO BE PROTECTED BY EXPANSION OF THEIR BENEFITS TO INCLUDE CATASTROPHIC HEALTH INSURANCE. SECOND, THE LARGE MAJORITY OF THE EMPLOYED WOULD BE ASSURED OF THE AVAILABILITY OF ADEQUATE PRIVATE INSURANCE PROTECTION BY REQUIRING EMPLOYERS TO MAKE AVAILABLE THIS BENEFIT TO ALL EMPLOYEES. THIRD, THOSE WHO ARE NEITHER

COVERED BY MEDICARE NOR EMPLOYED AND NOT ALREADY COVERED, COULD CHOOSE TO HAVE THE FEDERAL GOVERNMENT SERVE AS A FACILITATOR AND, IN SOME INSTANCES, A FINANCIAL BACK-UP, IN CONTRACTING WITH PRIVATE INSURANCE COMPANIES FOR CATASTROPHIC COVERAGE.

IT HAS BEEN NINE YEARS SINCE WE INTRODUCED THE "TRIPLE D" BILL. A LOT HAS OCCURRED SINCE THEN...IN 1983, WE PUT IN PLACE A NEW PROSPECTIVE PAYMENT SYSTEM THAT DRAMATICALLY ALTERED THE WAY THE MEDICARE PROGRAM PAYS HOSPITALS, RESULTING IN DECREASED LENGTHS OF STAY AND DECREASED RATES OF HOSPITALIZATION. SIMILARLY, MANY EMPLOYERS AND OTHER THIRD PARTY PAYORS HAVE INSTITUTED COST CONTROL EFFORTS AS WELL. AND JUST LAST YEAR, WE GAVE STATES THE OPTION TO EXPAND THEIR MEDICAID PROGRAMS TO INCLUDE MORE ELDERLY AND CHILDBEARING WOMEN.

BUT THERE ARE STILL GAPS IN THE SYSTEM AND THE LACK OF CATASTROPHIC COVERAGE IS ONE OF THOSE GAPS. IN RETROSPECT, MUCH OF WHAT WE PROPOSED BACK IN 1979 STILL SEEMS SOLID TODAY. FOR EXAMPLE, I ARGUED THEN AND CONTINUE TO BELIEVE TODAY THAT MANY OF OUR CONCERNS MAY BE WELL ADDRESSED THROUGH THE PRIVATE SECTOR. MOST AMERICANS ALREADY HAVE SOME FORM OF HEALTH INSURANCE. AND THAT INSURANCE IS PROVIDED THROUGH THE PRIVATE SECTOR. OUR SOLUTIONS SHOULD BUILD UPON THAT STRUCTURE AND NOT ATTEMPT TO EITHER DUPLICATE OR REPLACE IT.

CURRENT CONCERNS

AS WE PROCEED WITH OUR DELIBERATIONS AND OUR DISCUSSION TODAY, I HOPE THAT WE CAN KEEP IN MIND A NUMBER OF IMPORTANT FACTORS THAT NEED TO BE EMPHASIZED. WE CANNOT EXAMINE THE SUBJECT OF CATASTROPHIC HEALTH INSURANCE IN A VACUUM. THE REASON WHY WE ARE HERE TODAY IS BECAUSE WE KNOW THERE ARE NO SIMPLE SOLUTIONS TO THIS COMPLEX PROBLEM.

AS WE LOOK FOR SOLUTIONS, WE MUST BE CAUTIOUS ABOUT REVERSING SOME OF THE PROGRESS WE HAVE MADE IN OTHER AREAS. IN THE PAST, IN ORDER TO STIMULATE THE PRIVATE SECTOR TO PROVIDE HEALTH INSURANCE, TAX INCENTIVES WERE MADE AVAILABLE. THIS HAS WORKED WELL BUT, WE DON'T WANT TO START BLINDLY HANDING OUT TAX BREAKS, OTHERWISE KNOWN AS REVENUE LOSSES, IN ORDER TO SOLVE ALL THESE PROBLEMS. FOR EXAMPLE, TAX DEFERRED RETIREMENT ACCOUNTS FOR THE PURPOSE OF ENCOURAGING INDIVIDUAL SAVINGS FOR LONG TERM CARE MAY BE WORTHWHILE TO CONSIDER BUT IT WOULD BE A MISTAKE TO UNDO THE ENORMOUS ACCOMPLISHMENT OF TAX REFORM BY GOING BACK ON SOME OF THE HARD FOUGHT PROVISIONS THAT HELD THE PACKAGE TOGETHER.

SIMILARLY, WHILE WE CAN DO A GREAT DEAL THROUGH WORKING WITH EMPLOYERS, EMPLOYEES, AND THE PRIVATE SECTOR TO ENCOURAGE THE AVAILABILITY OF CATASTROPHIC HEALTH INSURANCE FOR EMPLOYEES, WE MUST BE CONCERNED ABOUT THE IMPACT ON EMPLOYMENT IF THE COSTS OF INSURANCE BECOMES PROHIBITIVE. AND, OF COURSE, WE MUST BE AWARE

OF THE FEDERAL DEFICIT AND OUR COMMITMENT TO TACKLING THAT PROBLEM. IN SHORT, WE MUST NOT ALLOW OUR SOLUTIONS TO RESULT IN CONSEQUENCES THAT ARE UNLIKELY TO AFFORD TRUE PROTECTION TO THE AMERICAN PEOPLE.

TIME TO REFOCUS

IN RECENT YEARS IN THIS COUNTRY, WE HAVE SEEN THE GROWTH OF SO-CALLED "FIRST-DOLLAR" COVERAGE, OFTEN REFERRED TO AS "FRONT-END" COVERAGE. IN PART, THIS EMPHASIS ON THE "FIRST-DOLLAR" HAS LED US AWAY FROM CONCERN ABOUT THAT "LAST DOLLAR". WE NEED TO DO A BETTER JOB OF MAKING AVAILABLE INSURANCE THAT PROTECTS AN INDIVIDUAL'S "LAST DOLLAR" AND THROWS THE VICTIMS OF CATASTROPHIC ILLNESSES AND THEIR FAMILIES INTO POVERTY.

I HAVE JOINED WITH A SEVERAL OF MY COLLEAGUES TO SEEK A SOLUTION TO THIS PROBLEM. FIRST, WE HAVE TURNED OUR ATTENTION TO CATASTROPHIC HEALTH INSURANCE COVERAGE FOR THOSE ON MEDICARE. OUR PRIORITY IS DEALING WITH ACUTE COVERAGE FIRST. WE ARE CAREFULLY EXPLORING WHETHER OR NOT THE PRIVATE INSURANCE MARKET CAN FULLY DEAL WITH THE ELDERLY OR WHETHER MEDICARE IS A MORE COST-EFFECTIVE SOURCE. THIS DOES NOT MEAN WE WILL IGNORE THE ISSUE OF LONG TERM CARE. THIS COMMITTEE WILL BE HOLDING HEARINGS SOON ON THIS ASPECT OF CATASTROPHIC ILLNESS EXPENSE.

FOR THOSE UNDER 65, I TRULY BELIEVE THAT THE PROBLEM CAN BE LARGELY DEALT WITH THROUGH THE PRIVATE SECTOR, MUCH AS WE PROPOSED IN 1979. HOWEVER, WE HAVE SEVERAL DIVERSE GROUPS WHO ARE INCLUDED IN THIS POPULATION AND OUR SOLUTIONS MUST FIT THEIR UNIQUE CIRCUMSTANCES. FOR THE EMPLOYED, EMPLOYMENT BASED OPTIONS SEEM TO MAKE THE MOST SENSE. FOR THOSE WHO ARE NEITHER EMPLOYED, AND HAVE NOT BEEN ABLE TO PURCHASE CATASTROPHIC HEALTH INSURANCE, THERE ARE A NUMBER OF OPTIONS THAT NEED TO BE FULLY EXPLORED, INCLUDING STATE INSURANCE RISK POOLS.

CONCLUSION

WE HAVE SET BEFORE US A BROAD CHALLENGE AND I AM GLAD THAT WE HAVE SO MANY STRONG SUPPORTS TO HELP US IN OUR QUEST. I KNOW THAT WE WILL NEED THE INPUT OF MANY BEFORE THIS JOB IS DONE. AND I, FOR ONE, LOOK FORWARD TO WORKING TOWARD A SOLUTION THAT LIFTS THE BURDEN OFF THOSE WHO ARE ALREADY INCREDIBLY BURDENED BY THE VERY NATURE OF THE SUFFERING THAT ACCOMPANIES THOSE WHO EXPERIENCE A CATASTROPHIC HEALTH EVENT. AND I WELCOME ANY CONTRIBUTION THE SECRETARY CAN MAKE TOWARD ACCOMPLISHING THAT END.

STATEMENT BY
SENATOR JOHN H. CHAFEE
AT
FINANCE COMMITTEE HEARING
ON
CATASTROPHIC HEALTH CARE
JANUARY 28, 1987

MR. CHAIRMAN, I AM PLEASED TO HAVE THE OPPORTUNITY TODAY TO THANK SECRETARY BOWEN FOR THE EXCELLENT WORK HE HAS DONE ON THE TOPIC OF CATASTROPHIC ILLNESS. THE INFORMATION AND RECOMMENDATIONS SECRETARY BOWEN PRESENTED IN HIS REPORT TO THE PRESIDENT HAVE BEEN EXTREMELY HELPFUL IN RAISING AWARENESS ABOUT THIS TROUBLING ISSUE.

IT IS CRITICAL THAT WE DEVELOP A GUIDING DEFINITION OF A CATASTROPHIC ILLNESS EXPENSE. IN MY OPINION, ANY HEALTH RELATED CRISIS WHICH HAS THE POTENTIAL OF FORCING AN INDIVIDUAL OR FAMILY INTO OR NEAR POVERTY IS CATASTROPHIC.

WHILE IT IS TRUE THAT BETWEEN THREE AND FOUR PERCENT OF MEDICARE BENEFICIARIES FACE OUT-OF-POCKET EXPENSES OF OVER $2,000 EACH YEAR, ABOUT FIVE PERCENT OF ALL ELDERLY INDIVIDUALS ARE IN NURSING HOMES AT ANY ONE POINT IN TIME AND THE LIFETIME RISK OF ENTERING A NURSING HOME IS ABOUT TWENTY PERCENT. THE AVERAGE COST OF ONE YEAR IN A NURSING HOME IS APPROXIMATELY $22,000.

FOR MOST OF THE ELDERLY, THE RISK OF NEEDING LONG TERM CARE AND ENTERING A NURSING HOME IS THEIR MOST PARALYZING FEAR. THEY HAVE GOOD REASON TO BE CONCERNED. AS SECRETARY BOWEN POINTS OUT IN HIS REPORT, ONE-HALF OF ALL NURSING HOME PAYMENTS ARE OUT-OF-POCKET EXPENDITURES BY THE ELDERLY AND ALMOST ALL THE REST ARE PAID BY THE MEDICAID PROGRAM. APPROXIMATELY ONE-HALF OF ALL MEDICAID RECIPIENTS IN NURSING HOMES WERE NOT INITIALLY POOR, BUT SPENT THEIR INCOME AND RESOURCES ON LONG TERM CARE BEFORE BECOMING ELIGIBLE FOR MEDICAID.

NO ELDERLY INDIVIDUAL OR COUPLE SHOULD BE FORCED INTO POVERTY BEFORE ASSISTANCE WILL BE PROVIDED FOR LONG TERM CARE FOR A CHRONIC ILLNESS OR DEBILITATING CONDITION LIKE ALZHEIMER'S DISEASE.

ANY CATASTROPHIC PROPOSAL, IF IT IS TO TRULY ADDRESS THE ISSUE OF CATASTROPHIC HEALTH CARE EXPENSES, MUST INCLUDE PROTECTION AGAINST THE IMPOVERISHMENT OF THE ELDERLY AS A RESULT OF THE COST OF LONG TERM CARE.

I AM DEVELOPING A PROPOSAL WHICH WOULD ADDRESS THE THREE MOST IMPORTANT HEALTH RELATED PROBLEMS THE ELDERLY FACE TODAY: EXPENSES INCURRED WHILE IN THE HOSPITAL; THE NEED FOR POST-HOSPITAL CARE; AND MOST CRITICAL, THE NEED FOR A VARIETY OF LONG TERM CARE SERVICES.

THE PROPOSAL WOULD RESTRUCTURE MEDICARE BENEFITS IN THE SAME WAY SECRETARY BOWEN'S RECOMMENDATIONS SUGGEST -- BY PLACING A CAP ON OUT-OF-POCKET EXPENDITURES BY THE ELDERLY. IN ADDITION, I WILL PROPOSE A NEW SET OF SERVICES FOR POST-HOSPITAL CARE, SUCH AS IN-HOME OR NURSING HOME CARE, TO ADDRESS THE PROBLEM OF ELDERLY INDIVIDUALS BEING DISCHARGED FROM THE HOSPITAL IN A FRAGILE CONDITION. A PREMIUM WOULD BE DETERMINED TO PAY FOR MOST OF THE COSTS OF THESE TWO NEW BENEFITS. FINALLY, MY PROPOSAL WILL ALLOW ELDERLY INDIVIDUALS POTENTIALLY AT RISK OF LOSING ALL OF THEIR ASSETS AND INCOME IN ORDER TO PAY FOR A CHRONIC ILLNESS OR DEBILITATING CONDITION, TO PAY AN INCOME ADJUSTED MONTHLY FEE TO THE MEDICAID PROGRAM AND RECEIVE A PACKAGE OF LONG TERM CARE SERVICES.

WHILE I REALIZE THAT THIS APPROACH MAY BE TOO AMBITIOUS, AND PERHAPS COSTLY, FOR US TO ENACT THIS YEAR, I BELIEVE IT OUTLINES THE CRITICAL ISSUES WE MUST ADDRESS IN THE LONG RUN. IN THE MEANTIME I WILL CONTINUE TO WORK WITH MY COLLEAGUES ON THIS COMMITTEE TO DEVELOP SOLUTIONS TO AS MUCH OF THE PROBLEM AS WE CAN AFFORD TO CORRECT THIS YEAR.

WE MUST ALSO REMEMBER THAT THE NEED FOR PROTECTION FROM CATASTROPHIC ILLNESS IS NOT LIMITED TO THE ELDERLY. AS SECRETARY BOWEN'S REPORT ACCURATELY POINTS OUT, THOSE UNDER SIXTY-FIVE ARE

ALSO AT RISK, AND THE NEEDS OF YOUNGER FAMILIES AND CHILDREN WITH CHRONIC ILLNESSES OR DISABILITIES MUST BE ADDRESSED.

WHILE WE HAVE ONE OF THE BEST HEALTH CARE SYSTEMS IN THE WORLD FOR SOME INDIVIDUALS, WE ALSO HAVE ENORMOUS UNMET NEEDS. THESE ARE CRITICAL NEEDS THAT MUST BE ADDRESSED IF WE ARE TO BE COMPETITIVE -- A HEALTHY WORKFORCE IS ONE OF OUR MOST IMPORTANT ASSETS.

WE HAVE OUR WORK CUT OUT FOR US IN THIS COMMITTEE THIS YEAR IF WE ARE TO SOLVE EVEN A FRACTION OF THE CATASTROPHIC ILLNESS PROBLEM. THE ISSUES ARE BROAD AND COMPLICATED, AND REAL SOLUTIONS MAY BE EXPENSIVE. I LOOK FORWARD TO ATTACKING THIS PROBLEM THIS YEAR WITH SECRETARY BOWEN'S GUIDANCE AND HELP.

STATEMENT BY SENATOR JOHN HEINZ (R-PA)
BEFORE THE SENATE FINANCE COMMITTEE
28 JANUARY 1987

Mr. Chairman, the Finance Committee meets once again this morning to look at short falls in our nation's health care programs--the loopholes and potholes, the coverage "black holes" that put too many Americans at risk.

We stand today at a crossroads. We must decide whether to strengthen our commitment to essential health services for all Americans, or cave to compulsive budgeteers and program polemics who say we've done enough.

Mr. Chairman, I think the choice is clear. While the President stopped short of endorsing the Bowen proposal in his State of the Union address last evening, the Secretary deserves credit for ushering the debate over catastrophic coverage into the national spotlight. While there are problems with the Secretary's proposal, it fills an invaluable role as a backboard off which to bounce more comprehensive solutions.

Mr. Secretary, I have read your proposal in its entirety with great interest. You deserve an "A" for your leadership and courage, both for recognizing the devastating potential of a catastrophic illness and for putting forth a framework for change. Rest assured that yours is not a lone voice in the wilderness. Your concerns are echoed by a chorus from this Committee and from others across the Hill.

I have done a more detailed analysis of your proposal Mr. Secretary, which I would be pleased to share with you. This analysis begins with my premise that a truely comprehensive proposal for acute and chronic health care coverage must meet four critical criteria.

First, it must rely on a joint public/private approach for financing.

Second, it must provide for a full range of services, from community-based to institutional, from catastrohpic acute to long term chronic.

Third, it must make coverage accessible and affordable for all Americans.

And finally, it must be cost-effective, without threatening quality.

Based on these criteria, Mr. Secretary, I find several areas where I would improve upon your proposal. You thread the needle to darn the holes in America's acute and long term care coverage. But your thread isn't long enough, nor strong enough, to mend the full range of problems we face.

The biggest weakness in your proposal, as I see it, is the limited set of options you offer for long term care. Your recommendations for tax credits, for example, by emphasizing institutional settings, invite care that is more expensive, perhaps inappropriate and even less desirable than care in a home or community. These long term care incentives, further, rely too heavily on solutions that are unlikely to help lower-income individuals and families.

When it comes to the elderly, your proposal would not really expand coverage beyond current services. For example, prescription drugs would remain an out-of-pocket expense. The proposal would not ensure access to coverage for those low-income individuals who do not get Medicaid and cannot afford the added Part B premium.

Mr. Secretary, again I commend you on what is a good beginning down the road to comprehensive health care coverage for Americans of every age and income.

Statement

Senator Dave Durenberger (R. Minnesota)

Hearing on Catastrophic Health Insurance

Senate Finance Committee

January 28, 1987

I applaud the Secretary's leadership in pressing to solve an important national problem. I regret that his solutions go no further than they do and that the President, although identifying the problem as a tragedy, has not yet decided to move ahead. But, I am glad that the Administration is concerned, continues to work on this issue and will submit a proposal soon.

This is an issue of long standing interest to me. I had the privilege and pleasure of representing the Senate on the Catastrophic Illness Advisory Committee. It was an important effort and I continue to commend the Secretary's leadership and urge him to stick to his beliefs about the importance of this problem. But, at the time of the report issuance, I expressed great concern about the report's failure to commit the federal government to assuring all Americans' protection against catastrophic health care expenses. I looked for strong conclusions and bold actions. Instead, we got tepid options. Ironically, and sadly, I note that last night's promise by the President seemed scaled down even further.

I do not, as I know my colleagues do not, intend to wait any longer. As I have since 1983, I will introduce catastrophic expense protection legislation aimed at both the over 65 and the disabled, and the under 65. The former would be tied to the Medicare program and the latter tied to employment and other insuring mechanisms for those not in the work force. I am working with my colleagues on the Finance Committee to develop legislation that can be reported out of our committee. But, I want to make it clear today that these piecemeal changes, the usual "disjointed incrementalism" of U. S. health policy, are just steps on the road to the comprehensive health care reform that we need - reform that addresses all of the problems and gaps in health policy in the country, and that these changes not be seen by anyone as ends in themselves.

We need, at the very least, to keep our eye on the long range goals and be clear that "a fix" here and "a fix" there do not solve or even begin to address other major problems, including the need for well-managed, effective, long term care programs that ensure that individuals get the right care at the right time, as we have seen succeed at On Lok in California and St. Anthony's Block Program in St. Paul.

But, the elderly and disabled are by no means the only people affected by catastrophic illness as the President and Dr. Bowen recognize. We must make certain that all Americans have access to catastrophic health insurance. I will reintroduce my 1985 Health Equity and Fairness Act which would require employers with 25 or more employees to offer protection against catastrophic hospital and physician expenses and to require continuity for that protection for employees and dependents.

The discussion over catastrophic coverage for Americans is not new. I know that the Finance Committee worked long and hard on this issue in the late 1970's. However, there has not been much discussion of it recently, so it is important to bring it back to the front burner.

Catastrophic coverage is no panacea. It will not prevent all hardship and by itself it does not address a number of failures in the system. A major study by the National Center for Health Services Research indicates that at least a quarter of the nonelderly population, more than 50 million people, are inadequately protected against the possibility of large medical bills. Many of these people are poor although many also have employer-provided insurance.

There is no reason that through employer based group insurance, we cannot assure employee's and their dependents protection against worst-case situations. This just makes sense from the standpoint of health policy and employee relations, and the additional costs will be very modest. Employers had been paying for some of these costs through "cost shifting". There will now be more explicit coverage and everyone can insist that they get their money's worth. This will also make case management systems all the more attractive.

Catastrophic Coverage Under Medicare

One of my bills, the Catastrophic Expense Protection Act, restructures Medicare and provides beneficiaries with catastrophic expense protection and different cost sharing.

The Medicare program has undergone considerable reforms since 1983, and they are good reforms. But our task is not complete. The prospective payment system must be expanded to include other providers of care, like physicians, skilled nursing facilities, home health agencies, and hospices.

Despite our success in restructuring payments to hospitals, we failed to address the need to restructure beneficiary cost-sharing, which has remained essentially unchanged since the creation of Medicare in 1965, in spite of revolutionary changes in other aspects of the program.

Medicare is an insurance program and should be designed first to protect the individual against the expenses incurred by a catastrophic illness. For Medicare, beneficiary cost-sharing should therefore be designed to allow beneficiaries to help prepay some of their costs and limit the beneficiary's liability for extraordinary expenses. Under present Medicare policy, there is no limit on the amount an individual beneficiary can expend out of pocket through Medicare cost-sharing. This makes no sense. Although the number affected is small in any given year, the effect can be devastating on the individual and the family. Further, there is considerable fear of being impoverished and the majority of elderly express a wish to have catastrophic protection to reduce those fears.

I have not worked out all of the details but the principles and the directions are clear.

*We need to move as quickly as possible to effective case management systems, chosen by the beneficiaries and other consumers.

*We need good prepayment and cost sharing mechanisms to allow beneficiaries to participate in payment for more routine costs.

*We must protect people from impoverishement and stress when they experience catastrophic illness.

MEDICARE: CATASTROPHIC COVERAGE PROPOSALS

Background Paper

I. OVERVIEW

Medicare is a nationwide health insurance program for 32 million aged and disabled persons. The benefits provided under the program are the same throughout the country. These benefits are targeted toward meeting the acute health care needs of the elderly. The program provides less effective protection against the costs associated with chronic illness, particularly those associated with long-term institutionalization. Further, the Medicare program places no upper limit on out-of-pocket costs paid by beneficiaries either in connection with covered program sevices or for all out-of-pocket health care expenses. The Medicare program itself therefore contains no catastrophic coverage provisions.

The combination of cost-sharing charges for covered Medicare services coupled with the potential for high out-of-pocket payments for uncovered services has led the majority of Medicare beneficiaries to purchase private insurance coverage (so-called Medigap coverage) to supplement the program's benefit package. The principal protection offered by the majority of these policies is coverage of Medicare's deductibles and coinsurance charges. Some Medigap policies cover a limited number of additional services such as prescription drugs. Few policies offer protection against the costs of long-term institutional care - potentially the most costly service item. Some low-income beneficiaries are also covered by Medicaid; however, many beneficiaries do not become eligible for Medicaid benefits until after they become institutionalized and reduce their incomes and resources to the Medicaid standard through their expenditures on health care.

The absence of catastrophic protection, both for the elderly and the population as a whole, has been the subject of concern for several years. The President in his 1986 State of the Union Message asked the Secretary of the Department of Health and Human Services (DHHS) to examine the issues and suggest possible solutions. Secretary Bowen submitted the Department's report to the President in November 1986 which recommended a shared public/private sector response.

While a number of persons have suggested that Medicare's protection should be expanded to offer catastrophic protection, there is no universal agreement on what should be done, or if in fact anything should be done at the Federal level. Generally, the catastrophic proposals which have been offered for the Medicare population would build on the existing Federal program. There are basically two broad categories of catastrophic proposals for this population group. The first category, which includes the proposal outlined in the Secretary's November 1986 Report to the President, would place an upper limit on beneficiary liability for Medicare deductibles and coinsurance; these proposals would also eliminate the durational limits on covered hospital services. Under this type of proposal, no catastrophic protection would be provided in connection with uncovered services. Assuming this coverage were instituted on a mandatory basis, it would have the effect of spreading the risk over the entire Medicare population. It is generally agreed that it would be relatively easy and inexpensive to administer. The major impact of this approach is that it could in large measure supplant existing Medigap policies offered by private insurance companies. However, this approach would not address a major concern of the elderly, namely the need for protection against the catastrophic costs of long-term institutional care. The second broad category of catastrophic coverage would attempt to provide protection against some of the costs associated with services currently not covered under the Medicare program (for example prescription drugs). Some, though not all, of these proposals would include long-term care expenditures in the benefit package. Several proposals would combine expanded protection with a restructuring of the current Medicare program.

A number of issues have been raised with regard to catastrophic/expanded benefit proposals. These include whether the Federal Medicare program should be altered from its current acute care focus, and if so how; and the appropriate role of both the public and the private sectors. A key concern is how a catastrophic/expanded benefit package would be financed. Options include increased payroll taxes, increased beneficiary premiums, higher coinsurance charges, Federal general revenues, or a combination of these. In view of the current budget deficit concerns, it may be difficult to achieve consensus on a proposal involving additional Federal outlays.

II. CURRENT PROGRAM

The Medicare program consists of two parts: the Hospital Insurance (Part A) program and the Supplementary Medical Insurance (Part B) program. The Part A program covers inpatient hospital services, post-hospital skilled nursing facility (SNF) services, home health services, and hospice care. With the exception of home health services, the law places specified limits on the amount of coverage that is available under each benefit category and imposes specified cost-sharing charges for the use of covered services. Coverage of hospital and SNF services is linked to the individual's benefit period. A benefit period is defined as beginning when a beneficiary enters a hospital and ending when he or she has not been in a hospital or SNF for 60 days.

Beneficiaries enrolled in Part B pay a monthly premium which is $17.90 per month in 1987. The program covers physicians' services (including those provided in a hospital) and a range of other health services including outpatient hospital services, durable medical equipment, laboratory and X-ray services, and physical therapy services. The program generally covers 80 percent of the "reasonable charge" for such services after the beneficiary has met a $75 deductible. The beneficiary is liable for the remaining 20 percent (known as the coinsurance). In addition, where a physician or other proivider does not accept "assignment" (i.e. agree to accept Medicare's determination of the reasonable charge amount as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge amount and the physician's actual charge. (This is sometimes referred to as the "balance billed" amount).

See Table 1 for a summary of benefits under Parts A and B and associated cost-sharing charges.

Table 1. Medicare: Summary of Benefits and Associated Beneficiary Cost-Sharing Charges, 1987

Coverage	Beneficiary Payments
Part A	
Inpatient Hospital Services a/	
- Per benefit period:	
- - First 60 days	$520 deductible b/
- - 61st - 90th day	$130 daily coinsurance b/
- 60 lifetime reserve days	$260 daily coinsurance b/
Post-hospital SNF services	
- First 20 days	None
- 21st - 100th day	$65 daily coinsurance b/
Home health services	None
Hospice services	Subject to durational limits and copayments for outpatient drugs and respite care
Part B	
Physicians services and other medical services a/	1) $75 deductible 2) 20% coinsurance 3) Amounts in excess of reasonable charges on unassigned claims (balance billing)

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a/ Special limits apply with respect to inpatient services in a psychiatric hospital under Part A and outpatient psychiatric physician's services under Part B. Limits are also applied to annual program payments for physical therapy services provided by an independent practitioner.

b/ Part A deductible and coinsurance amounts are increased annually; coinsurance amounts are calculated as specified percentages of the deductible.

III. ISSUES

A. Acute Care Focus of Program - Coverage Gaps [1]

The original Medicare program was designed to meet the acute health care needs of the elderly. The acute care focus is evidenced in the benefit design of the Part A and Part B program with its fairly extensive coverage of short-term hospital stays and in its coverage of a significant portion of the costs of physician's services. Nationwide, the program covered $40.5 billion, or 74.8 percent of the costs of hospital services for the aged in 1984. These figures reflect the fact that Medicare covers almost all aged persons (about 97 percent of the elderly) and that a very small percentage (0.7 percent in 1983) exceed the 60 day hospital limit in a benefit period and an even smaller percentage (0.02 percent in 1985) exhaust their lifetime reserve days. In addition, the program covered $14.3 billion, or 57.8 percent of the costs of physicians services for the aged in 1984.

At the same time the program offers less adequate protection against the costs of many other services frequently used by this population group. Overall, Medicare covered $58.5 billion--only 48.8 percent of the aged's health care costs in 1984. The program's benefit package excludes

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1/ Data in subsection A and D generally are from: Waldo, Daniel and Lazenby, Helen. Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984; in Health Care Financing Review, Fall 1984, vol. 6, n. 1; Fall 1984.

prescription drugs, routine eye examinations, eyeglasses, hearing aids, dental care, dentures, and most preventive care.

The major gap in the Medicare benefit package is coverage of most long-term care services. Program coverage is limited to short-term post-hospital stays in SNFs. As a result, Medicare covered only $539 million, or 2.1 percent of the nursing home costs of the aged in 1984.

B. Absence of Catastrophic Protection [2/]

Medicare's health insurance protection is further limited by the absence of catastrophic protection either for all out-of pocket health care expenses or for out-of pocket expenses in connection with covered program services. The liability for uncovered expenses is distributed unevenly throughout the Medicare population, depending on such factors as age, income level, incidence of acute illness, the presence of chronic conditions, and other insurance coverage. The majority of beneficiaries can be expected to face reasonable expenses in any given year. However, for a small portion of the population these costs may be viewed as excessive and sometimes catastrophic in nature.

Catastrophic medical costs are broadly defined as large unpredictable health care expenses; these are usually associated with a major illness or serious injury. Two methods are commonly employed to determine whether an individual's expenses are catastrophic in nature. The first standard measures total expenditures and defines anything over a specified amount, e.g. $2,000 or $4,000 as catastrophic. The second standard is based on expenditures that are large relative to an individual's income, e.g.

2/ The data in this section are from the Department's Report to the President, Catastrophic Illness Expenses, November 1986.

expenses over 5 percent or 10 percent of income. The Department of Health and Human Services feels that a combination of these methods is appropriate. A threshold amount is established below which no expense level is considered catastrophic regardless of income; a percentage of income figure is then added to that amount to yield the threshold above which expenditures are considered catastrophic. Using varying thresholds and percentage of income figures, the Department estimated that the incidence of aged persons with catastrophic out-of-pocket expenditures (i.e. expenditures not met by other public or private sources) ranges from 0.9 to 2.1 million persons, or 3.4 percent to 8 percent of the aged. (This is considerably higher than the 1.5 percent - 3.4 percent recorded for the general population).

A portion of these out-of-pocket expenses are for Medicare cost sharing charges and charges above Medicare's reasonable charge amounts on unassigned claims for physicians' services. The Health Care Financing Administration's Office of the Actuary has estimated the distribution of net beneficiary liabilities in connection with covered Medicare services. (These figures underestimate liabilites since they do not include expenses for uncovered services, for example SNF services in excess of the 100 day limitation. Also, the figures do not include offsets for amounts paid by private health insurance policies. Therefore these figures do not represent actual out-of-pocket liabilities in connection with Medicare services.) In 1983, 2.8 million, or 10.3 percent of beneficiaries had annual liabilities of $1,000 or more; these accounted for 54.2 percent of the total $10.3 billion in such liabilities. A subgroup of this population, beneficiaries with $2,000 or more in liabilites, accounted for 800,000 or 3.1 percent of total beneficiaries and 28.2 percent of total liabilities. Beneficiairies with the highest liabilities, namely $5,000 or over, accounted for 100,000 persons--or 0.4 percent of the beneficiary population.

Twenty-eight percent of liabilities are in connection with Part A services and 72 percent in connection with Part B services. The distribution of such liabilities is as follows: hospital deductible - 21.7 percent; hospital coinsurance - 4.6 percent; SNF coinsurance - 1.7 percent; Part B deductible - 14.3 percent; Part B coinsurance - 35.5 percent; and charges above reasonable charge amount on unassigned claims - 22.2 percent.

C. Other Third-Party Coverage

The combination of cost-sharing charges for covered Medicare services coupled with the potential for high out-of-pocket payments for uncovered services has led the majority of Medicare beneficiaries to purchase private insurance coverage to supplement the program's benefit package. This protection, frequently referred to as Medigap coverage, is purchased by an estimated 65 percent of Medicare enrollees. There is considerable variation in the coverage offered under various Medigap policies. The principal protection offered by the majority of these policies is coverage of Medicare's deductibles and coinsurance charges. Many policies also provide protection against the costs of hospital stays exceeding Medicare's coverage limits; however, few policies cover charges above Medicare's reasonable charge amount on unassigned claims for physicians' services. Some Medigap policies cover a limited number of additional services such as prescription drugs. Few policies offer protection against the costs of long-term institutional care - potentially the most costly service item. Thus, despite the fact that a beneficiary may have purchased one or more private policies he or she may not have adequate insurance protection for the full range of medical expenses.

In 1980, the Congress amended the Social Security Act to provide standards for policies marketed as Medigap insurance. These amendments, known as the Baucus amendments, incorporated by reference the Medigap standards contained in a model regulatory program developed by the National Association of Insurance Commissioners (NAIC). If a State has adopted laws and/or regulations at least as stringent as those of the NAIC, policies regulated by the State are deemed to meet Federal requirements. Currently 46 States, the District of Columbia, and Puerto Rico meet these requirements.

Some low-income beneficiaries are also covered by Medicaid (the Federal-State health care program for certain low-income individuals including the aged and the disabled). About 13 percent of aged Medicare beneficiaries have such protection. Medicaid generally picks up the cost-sharing charges on behalf of these dual eligibles. However, the primary Medicaid benefits used by the dual eligibles are long-term care services - either those provided in SNFs or in intermediate care facilities (ICFs). In fact, many beneficiaries do not become eligible for Medicaid benefits until after they become institutionalized and reduce their incomes and resources to the Medicaid standards through expenditures on health care.

Approximately 20 percent of the Medicare population has no other health insurance coverage. According to DHHS, this figure includes over 2 million poor and six million near-poor elderly not covered by Medicaid.

D. Out-of-Pocket Payments.

In 1984, total per capita spending by the aged for health care was $4,202. Of this amount, $1,059 (or 25.2 percent of the total) represented out-of-pocket payments by the elderly, that is payments not met by third-party payment sources such as government programs or private insurance. These out-of-pocket figures do not include the additional amounts spent by the elderly for payment of Part B premiums ($17.90/month in 1987) or private insurance premiums. These figures are averages and may be higher or lower for individual beneficiaries depending on individual circumstances.

Out-of-pocket payments have declined as a percentage of total health payments since the inception of Medicare (dropping from 53.2 percent in 1966 to 25.2 percent in 1984). However, mean out-of-pocket payments (including insurance premiums) as a percentage of mean income is estimated to be the same as that recorded prior to the start of the program - 15 percent in both 1966 and 1984.

The notably sharp increase in the Part A deductible in the past several years has focused increased attention on beneficiary payments. The deductible rose from $356 in 1984 to $400 in 1985 (12.4 percent rise), and to $492 in 1986 (23 percent rise). In the absence of any legislative change, the figure would have increased to $572 in 1987 (a 16.3 percent rise). However, the Omnibus Budget Reconciliation Act of 1986 (P.L. 99 - 509) set the 1987 deductible at $520; further, it revised the calculation of the deductible so that future increases will be more moderate.

E. Demographic Changes

Demographic changes coupled with medical advances are fostering increasing demands on the health system. The aged population is increasing both in numbers and as a proportion of the population as a whole. The Bureau of the Census reports that from 1970 to 1984, the number of persons aged 65 and older rose from 20.1 million and 9.8 percent of the population to 28.0 million and 11.9 percent of the population.

Life expectancy is also increasing. Persons turning age 65 in 1984 could expect to live an additional 16.8 years, more than two years longer than when Medicare began. Of particular importance to the health care system is the increasing number of the "oldest old", i.e. person over age 85. These persons are more likely to experience some form of functional impairment. In 1984, 18.7 percent of this age group were institutionalized compared with 1.1 percent of those aged 65-69.

In 1984, the median income of families headed by persons 65 or older was $18,215; the median income of an unrelated individual in the same age group was $7,296. (There were 9.8 million such families and 7.3 millions such unrelated individuals.) This compares to $24,433 for all families and $11,204 for all unrelated individuals. Data from the 1980 Census of Population and Housing show that the cash income of the elderly is lower in each older age group. Married couples with a head aged 65-69 had median incomes of $18,400, compared to $11,200 for those 85 and over. Men aged 65 to 69 and living alone had median incomes of $8,200, while those 85 and over had incomes of $6,000; the comparable figures for women living alone were $6,800 and $5,200, respectively.

F. Long-term Care

The program offers little protection for the costs of nursing home and custodial care services required by chronically ill persons over an extended time period. The range of conditions which may result in the need for long-term care services is extensive; many of the conditions are difficult to treat medically except to maintain the status quo of the patient. Dementia, the chronic, often progressive loss of intellectual funtion, is also a major cause of disability frequently necessitating long-term institutional care. Over half and perhaps as many as 70 percent of patients with dementia have Alzheimer's disease, a chronic progressive neurologic degeneration of unknown cause.

Financing of possible stays in nursing homes is one of the most pressing health-related concerns of the elderly. Medicare covered only 2 percent of the nursing home expenses of the elderly in 1984. The Federal-State Medicaid program picked up an additional 42 percent. Six percent came from a combination of other government and private sources with only 1 percent paid for by insurance. Fifty percent of all nursing home expenditures for the elderly were paid for out-of-pocket. Many of the elderly purchasing Medigap protection are not aware that their policies do not in fact offer this protection.

Individuals can only gain coverage under Medicaid after they have reduced their incomes and resources to the State-established eligibility levels. Many elderly dread the prospect of impoverishing themselves to these welfare levels. However, since there is limited coverage of long-term care services under either public programs or most private insurance policies, Medicaid is by default the primary source of third-party financing of long-term care services. At the same time there is a growing concern that Medicaid is moving toward a long-term care program for the elderly, many of whom were previously middle income. This raises questions with respect to the competing demands of other population groups, namely the low-income non-elderly, for limited resources.

IV. CATASTROPHIC HEALTH INSURANCE PROPOSALS FOR THE AGED

Catastrophic health insurance coverage, either for the poplulation as a whole, or just for the Medicare-eligible population, is likely to be an issue in the 100th Congress. This is not a new issue for the Congress. The absence of adequate catastrophic protection for certain segments of the population has been a subject of concern for a number of years, and Congress has been asked to consider a broad range of options to address the problem. While proposals are likely to be advanced which deal with the population as a whole, the primary focus of consideration this Congress will probably be modifications to the Medicare program. While a number of persons have suggested that Medicare's protection should be expanded to offer catastrophic protection, there is no universal agreement on what should be done, or if in fact anything should be done at the Federal level.

Generally, the catastrophic proposals which have been offered for the Medicare population would build on the existing Federal program. There are basically two broad categories of catastrophic proposals for this population group. The first category would place an upper limit on beneficiary liability for Medicare deductibles and coinsurance; these proposals would also eliminate the durational limits on covered hospital services. Under this type of proposal, no catastrophic protection would be provided in connection with uncovered services. Assuming this coverage were instituted on a mandatory basis, it would have the effect of spreading the risk over the entire Medicare population. It is generally agreed that it would be relatively easy and inexpensive to administer. The major impact of this approach is that it could in large measure supplant existing Medigap policies offered by private insurance companies. However, this approach would not address the major catastrophic concern of the elderly, namely the need for protection against the costs of long-term institutional care.

The second broad category of catastrophic coverage would attempt to provide protection against some of the costs associated with services currently not covered under the Medicare program (for example prescription drugs). Some, though not all, of these proposals would include long-term care expenditures in the benefit package. Several proposals would combine expanded protection with a restructuring of the current Medicare program.

A number of issues have been raised with regard to catastrophic/expanded benefit proposals. Those who are against expanding the Federal role note that the majority of Medicare beneficiaries have supplementary coverage, primarily through Medigap policies. They suggest that efforts should be made to expand rather than supplant the role of the private sector. Further they feel that it is inappropriate to be considering expanded Medicare coverage both in light of the overall Federal deficit and the impending insolvency of the Part A trust fund (currently slated for the late 1990s).

Those who favor expanding the Federal role in this area do so for several reasons. They suggest that there are gaps in health care coverage of the elderly that are not currently being addressed; this is particularly so for the 20 percent of the Medicare population that has no supplementary coverage. They note that an administrative structure is already in place to implement an expanded benefit. Those favoring a modest expansion in coverage, namely just placing an upper limit on out-of-pocket payments for Medicare deductibles and coinsurance, suggest that this expansion can be achieved with no additional cost to the Federal government and small predictable increases in beneficiary payments. They further suggest that beneficiaies would in many cases pay substantially less than what they are currently paying for comparable Medigap coverage. Those favoring a more expansive Federal role feel it is appropriate to respond to the existing coverage gaps, particularly coverage of long-term care services, at the national level.

A key concern is how a catastrophic/expanded benefit package would be financed. Options include increased payroll taxes, increased beneficiary premiums, higher coinsurance charges, Federal general revenues, or a combination of these. In view of the current budget deficit concerns, it may be difficult to achieve consensus on a proposal involving additional Federal outlays.

The following sections outline the major catastrophic proposals which have been offered over the past several years. They are followed by a chart which summarizes the major Medicare provisions of four of these proposals.

A. Secretary Bowen's Report to the President (November 1986)

In his February 1986 State of the Union Message, the President asked the Secretary of DHHS to examine the issue of catastrophic protection for all age groups (not just for the Medicare population) and report recommendations to him by the end of the year. The Secretary appointed a Private/Public Sector Advisory Committee on Catastrophic Illness to assist him in the examination of the issues. That Committee reported to the Secretary in August 1986 outlining the policy options and indicating its support for a shared pubic/private sector response. Secretary Bowen transmitted the Department's Report to the President, "Catastrophic Illness Expenses", in Novemeber 1986. This report identified three major components of the catastrophic coverage problem, namely, acute catastrophic protection for the elderly, long-term care protection alternatives; and catastrophic protection for the general population. It identified the policy options for each component and presented preferred alternatives.

With respect to the elderly population, the report recommended placing an annual limit on each beneficiary's out-of-pocket expenses for all Part A and Part B deductibles and coinsurance. Part A coinsurance would be removed and the maximum number of hospital deductibles would be set at two per year. Catastrophic coverage with a $2,000 annual limit on deductibles and coinsurance would require an additional annual premium of $59. This cost, i.e. $4.92/month would be added to the Part B premium. The benefit would be fully funded by the premium and be indexed annually.

The Report indicated that this proposal would spread the cost of catastrophic protection across the beneficiary population which purchases Part B coverage (over 95 percent of Part A beneficiaires purchase Part B protection). Minimal overhead would be involved and no expansion of government bureaucracy would be required. The Report indicated that the proposal would be favored by the elderly for several reasons including their faith in the Medicare program itself and the fact that the increased premiums are both budgetable and predictable. The Report also stated that private insurers would continue to have a role with respect to the Medicare population.

While the Report recommended that the expanded coverage be financed through an actuarially sound premium, it also offered two alternative (though, it stated, less preferable) recommendations. One proposal would restructure Medicare to provide catastrophic protection with increased cost sharing related to income. The second proposal would provide for such restucturing unrelated to income. Both proposals would shift program coverage away from initial health care costs to pay for extremely high annual costs. The Report noted that there were several ways such a plan could be designed. It presented an example of the increased coinsurance that would be required (assuming a payment structure unrelated to income) for a plan limiting out-of-pocket expenses to $2,000 and placing a limit of two hospital deductibles per year. The requisite coinsurance would be $10 per day for days 2 - 11 of inpatient hospital care (currently not subject to coinsurance); SNF coinsurance of 10 percent of the average daily cost of care for up to 100 days of care (currently the coinsurance is one-eighth of the inpatient hospital deductible for days 21 - 100); home health coinsurance of 10 percent of the average visit cost for up to 100 visits (currently no coinsurance is imposed); and an increase in the Part B deductible from $75 to $170. If the coinsurance amounts were income-related, higher coinsurance charges would be required for higher income beneficiaries to offset any reduction for lower income beneficiaries.

In presenting the alternatives the Report noted that it would spread the cost over all beneficiaries not just Part B beneficiaires. However, it noted the main weakness was that the cost would be borne only by the users of health services and therefore would be a tax on the cost of illness. The Report does not mention that these alternatives would likely be viewed as a reduction rather than an expansion in benefits.

The Report also examined long term care protection alternatives. A limited Federal role is proposed in this area. Specific recommendations included in the Report were as follows:

-- The Federal government should work with the private sector to educate the public about the risks,costs, and financing options available for long-term care as well as the limitations of coverage under Medicare and Medigap.

-- The Federal government should encourage personal savings for long term care through a tax-favored Individual Medical Account (IMA).

-- The private market for long-term care insurance should be encouraged in several ways including a 50 percent refundable tax credit for long-term care insurance purchased by persons 55 or older.

-- The Federal government should set an example for private employers by offering employee-paid long term care group insurance as an option under the Federal Employees Health Benefit Program.

In addition, the report considered options for increasing the availability of acute care catastrophic health insurance for the non-elderly population. As with its recommendations regarding long-term care, the Report proposed limited Federal involvement. The Report included four specific proposals in this area:

-- States should require all employers who offer health insurance coverage to their employees to offer a catastrophic coverage option.

-- Full tax deductions should be extended for health insurance to the self-employed and unincorporated businesses, as long as the coverage includes catastrophic expenses.

-- States should form risk pools to subsidize insurance for those whose medical condition makes it impossible or prohibitively expensive to get catastrophic insurance.

-- State innovation and initiative should be encouraged in such areas as loan guarantees, high-deductible catastrophic health insurance requirements for motor vehicle registrations, and in greater flexibility in managing State Medicaid programs.

B. Bentsen Bill (March 1985)

The Health Care Catastrophic Loss Prevention Act of 1985, S. 569, would establish limits on beneficiaries' out-of-pocket expenses for Medicare covered services. This bill creates separate limits under Part A and Part B. The additional benefits are fully financed by separate beneficiary premiums under each part.

Under Part A, a catastrophic "cap" on out-of-pocket expenses is created through a restructuring of Part A benefits and coinsurance obligations. No actual dollar cap is specified. The Act would provide unlimited coverage for inpatient hospital care. The current coinsurance charges for inpatient days over 60 in a benefit period would be eliminated, as would be the limits on inpatient coverage under the lifetime reserve day provisions. Beneficiary cost-sharing for inpatient care would be limited to the inpatient hospital deductible and this deductible would not apply to more than two spells of illness per year. The Act would also expand Medicare coverage of care in a skilled nursing facility (SNF) from 100 to 150 days per benefit period. The daily coinsurance for SNF services would also be restructured. Currently, beneficiaries are liable for a daily coinsurance, equal to one-eighth of the inpatient hospital deductible, after 20 days of SNF care. This proposal would set the amount of the daily coinsurance to 15 percent of the average per diem cost for post-hospital extended care services within the region. In addition, the daily coinsurance amount would be due for each of the first 10 days of SNF care, rather than for days after 20.

The additional Part A benefits would be fully financed by beneficiary premiums. Collection of this premium would be on a monthly basis in the same manner as the Part B premium is currently collected. If a beneficiary had insurance from other sources, at no cost (such as through a retiree health benefit plan) of greater or equal value, the individual could waive the additional benefits and not be required to pay the Part A premium. Except for these individuals, participation in the Part A component of this plan would be mandatory.

Under Part B, S. 569 would create an explicit cap on deductible and coinsurance amounts for covered services of $1,000 per calendar year (1986). The level of the cap would be adjusted in subsequent years according to the Medicare Economic Index (MEI). The catastrophic benefit under Part B would be an optional benefit. This benefit would be fully financed by a separately identified beneficiary premium, payable by Part B enrollees electing the coverage.

While the bill did not directly address the issues of catastrophic health care costs for long-term care services, it would establish a Commission on Long-term Care Services. This Commission, appointed by the Secretary of Health and Human Services, would conduct a study of how the Medicare program might better provide protection against the catastrophic costs of long-term care.

C. Durenberger Bill (May 1985)

The "Health Equity and Fairness Act of 1985," S. 1211, introduced by Senator Durenberger, would include catastrophic protection provisions in its three-part proposal on health insurance coverage for the working population. First, this bill would amend the Internal Revenue Code to place a limit on an employer's contribution toward a health benefit plan which could be excluded from an individual's gross income. The limit or "tax cap" above which employer paid premiums would be taxable for individuals would be $100 per month for an employee with single coverage and $250 per month for an employee with family coverage. This tax cap would be adjusted annually to reflect changes for inflation.

Second, the bill would amend the Internal Revenue Code to provide a deduction for payments to a qualified health benefits plan by individuals not covered under an employer provided health plan (the self-employed and unemployed). The deduction could be taken for premium payments below the tax cap of $100 per month for an individual and $250 for a family. The deduction would be allowed only for qualified health benefits plans. These plans would be required to cover physician and hospital inpatient and outpatient services. They could not provide exclusions or restrictions on coverage based upon prior medical condition. They would also be required to provide catastrophic expense protection against out-of-pocket medical expenses in excess of $3,500. After the expense of $3,500, the plan would be required to pay 100 percent of otherwise allowable physician and hospital inpatient and outpatient hospital services during a year. Qualified plans would be prohibited from cancelling coverage for any reason based on the status or action of the covered individuals, other than non-payment of premiums.

Finally, the bill would require employers who have over 25 employees and who provide benefit plans to include in those plans the catastrophic coverage described above. The catastrophic expense protection would be triggered after an expenditure of $3,500 and would be effective for the calendar year in which it was triggered. In addition, the employer would be required to provide an individual or family which loses eligibility for coverage by that employer's group the option to continue coverage by the group for at least 1 year. Eligibility for continued coverage would be available to persons who lose membership in an employment group due to termination of employment, death of the subscriber, divorce from the subscriber, or loss of dependent status because of age or loss of student status. The subscriber could be charged premiums during this period, but the premium could not exceed 110 percent of the applicable group rate.

D. Dole/Danforth/Domenici Bill (March 1979)

The "Catastrophic Health Insurance and Medicare Improvements Act of 1979," S. 748, introduced by Senators Dole, Danforth, and Domenici would create a national system of catastrophic health insurance protection based on three approaches: (1) amending the Medicare program to extend catastrophic protection to Medicare beneficiaries; (2) requiring employers to offer catastrophic health insurance coverage to full-time employers; and (3) establishing a residual market catastrophic health insurance program for those with no other catastrophic coverage. In addition, State Medicaid programs would be required either to offer Medicaid beneficiaries catastrophic coverage equal to that of the residual plan or to buy into the residual plan.

With regard to Medicare Part A benefits, the bill would delete the limitation on the number of hospital days covered and eliminate all copayment requirements, but would retain the deductible for hospital care. The bill would eliminate copayment requirements for SNF care and make certain other changes enacted into law in 1980 with regard to increasing the period during which Medicare beneficiaries could enter and re-enter a SNF after discharge from a hospital. The bill also contained provisions which would liberalize certain requirements for Medicare's home health benefit, some of which were enacted into law in 1980. In addition, the bill proposed to increase coverage of outpatient psychiatric benefits.

Catastrophic coverage for Part B services would be triggered when a Medicare beneficiary had incurred medical expenses of $5,000 in a year for covered services, or had spent an amount equal to 20 percent of that deductible out-of-pocket for these same services. Expenditures for certain outpatient prescription drugs, listed in a special formulary and necessary for the treatment of certain chronic conditions could be counted toward meeting the catastrophic deductible. Once the catastrophic deductible had been met, the Medicare program would pay 100 percent of reasonable charges for Part B services and for drugs listed in the formulary. Catastrophic coverage would cease after an individual incurred less than $500 in covered expenses in any 90-day period.

The employer-based provisions of the bill would provide coverage similar to that provided under the expanded Medicare program. Inpatient hospital services would be covered without cost-sharing after an individual or family unit had been hospitalized for 60 days. Medicare Part B-type physician and medical services would be covered without cost-sharing after an individual or family unit incurred $5,000 in medical expenses for such servcies. Employers would be required to cover all employees who were employed for 30 days and work at least 25 hours per week without regard to health status. In addition, enrollment would have to be offered to employees experiencing a change in circumstances, such as death of a spouse, divorce, marriage.

Employers and employees could claim deductions for health insurance premiums only if the policy contained the required catastrophic coverage. Employers whose payroll costs increased more than 2 percent as a result of complying with the program's requirements would receive a special Federal tax credit for up to 5 years. The credit would be equal to 50 percent of the total amount above the 2 percent increase the first year, and would decrease by 10 percent in each of the succeeding 4 years.

The bill's residual plan would provide for agreements with private insurance companies for the availability of catastrophic insurance for those not covered under medicare, Medicaid, or other private insurance. The Federal Government would subsidize the premiums for persons with low incomes insured under these agreements. The bill would also modify Medicaid to provide similar coverage under that program. These policies would cover the same benefits as mandated under the employer-based plans. Catastrophic coverage would be available for individuals who incurred out-of-pocket expenses for covered services equal to 15 percent of income (but not less than $200).

E. Long Bills (February and March 1979)

In 1979 Senator Long introduced legislation dealing with catastrophic health insurance. S. 350 and S. 351, introduced in February, would have established a Catastrophic Health Insurance Plan which would provide catastrophic insurance protection for all legal U.S. residents. A subsequent bill introduced by Senator Long in March, S. 760, revised some of the catastrophic insurance provisions of S. 350 and S. 351. In addition, S. 350 would have replaced the Medicaid program authority with a uniform national program of medical benefits for low-income persons. These provisions for a Medical Assistance Plan were not included in S. 351.

Under the Catastrophic Health Insurance Program, catastrophic protection would be available to all residents through either:

(1) A federally administered plan for the unemployed, welfare recipients, the aged, and persons who do not opt for private insurance coverage; or

(2) Approved private catastrophic insurance plans allowed as an option for employer-groups and the self-employed.

The Catastrophic Health Insurance Plan would provide benefits comparable to those available under Medicare Parts A and B, except that there would be no upper limitation on hospital days or home health visits (the home health visit limitation under Medicare was eliminated in 1980). Institutional benefits (hospital care, 100 days of post-hospital extended care, and home health services) would be covered after an individual had been hospitalized for a total of 60 days within one year. Medical benefits (similar to those provided under Medicare Part B with some limits placed on mental health services) would be covered after an individual or family had incurred medical expenses of $2,000 (annually adjusted) for physicians' services, home health visits, physical therapy services, laboratory and x-ray and other covered medical and health services.

Once the hospital or medical deductible (60 days or $2,000) had been met, the individual would not be charged for covered services. Institutional coverage would cease after an individual had not been an inpatient of either a hospital or a skilled nursing facility for 90 days. Similarly, medical benefits would cease following the first 90-day period during which the individual or family had incurred less than $500 in covered medical expenses.

The Catastrophic Health Insurance Plan would be financed through a 1 percent tax on the payroll of employers and the income of the self-employed subject to the social security tax. No employee contribution would be allowed. Amounts collected as taxes would be deposited in a Federal Catastropohic Health Insurance Trust Fund. An employer or self-employed individual who opted for a private plan could deduct the amount of the premium for private coverage from the 1 percent payroll tax liability. However, the employer would remain liable for payment to the Federal Government of any difference between the amount paid as premiums for a private plan and the 1 percent Federal tax liability. (S. 760 as later introduced by Senator Long would have eliminated the payroll tax provisions of S. 350 and replaced them with a requirement for employers to provide catastrophic coverage.)

Publicly-insured employers and self-employed individuals would be eligible for a catastrophic health insurance tax credit equal to 50 percent of the amount paid as payroll tax liability. Similarly, privately-insured employers and self-employed persons would also be eligible for a 50 percent tax credit on the amount paid as premiums for approved private catastrophic insurance, as well as a 50 percent tax credit on any additional amount paid to meet the 1 percent Federal payroll tax liability.

Employers and self-employed persons opting for private coverage would pay premiums directly to the carriers. The bill would require that employer plans administered through private carriers make available to the employer certain arrangements for the pooling of risks so that premiums could be determined on a class, rather than an individual, basis.

The Medical Assistance Plan for low-income persons (under S. 350) would be available to all persons eligible for Medicaid benefits and all individuals and families having an annual income at or below certain levels. It would cover certain specified benefits, generally without any limit on the amount of services or any cost-sharing required. The program would be financed from Federal general revenues and from State funds.

F. Reagan 1984 Budget Proposal (February 1983)

The Reagan FY84 Budget included a plan to restructure beneficiary cost-sharing for Part A and to provide coverage for an unlimited number of hospital days. Under the plan (outlined in a Presidential Message, "Health Incentives Reform Program", February, 28,1983), the following changes would be made in the cost-sharing structure for Medicare Part A benefits:

-- Elimination of patient cost-sharing charges for any hospital days of care after 60 days during any calendar year.

-- Imposition of new cost-sharing charges on the first days of inpatient care: a daily copayment equal to 8 percent of the inpatient deductible from day 2 to day 15 and a daily copayment amount equal to 5 percent of the inpatient hospital deductible for each day of care from the 16th through 60th day of hospitalization in any benefit period.

-- Limitation on the number of times a beneficiary must pay an inpatient hospital deductible to two in each year.

-- Reduction in the copayment amount applicable to care in skilled nursing facilities from the current level (12.5 percent of the inpatient hospital deductible amount) to 5 percent of the deductible.

The Administration's catastrophic proposal was also a spending reduction proposal. The catastrophic provisions would affect relatively few beneficiaries since only an estimated 0.7 percent exceed the 60 day hospital limit in a benefit period. However, every beneficiary using inpatient hospital services would be liable for increased coinsurance charges. It was estimated that the annual increase in costs to beneficiaries using hospital services would have been approximately $250 in calendar year 1984. The Administration estimated a 3-year savings from the proposal at $4.1 billion.

G. 1982 Advisory Council on Social Security (December 1983)

The 1982 Advisory Council on Social Security was requested to focus its attention on the Medicare program. Particular attention was placed on ways to maintain the fiscal integrity of the Part A program. On December 31, 1983, the Council made a series of recommendations for improvements in the Medicare program. The package included proposals relating to financing, eligiblity, benefit structure, and program reimbursement. The major elements of the benefit restructuring portion of the proposal were as follows:

- Modifying the hospital benefit under the Part A program to provide:
  - unlimited hospital days per calendar year;
  - a maximum of two hospital deductibles per year;
  - a daily coinsurance equal to 3 percent of the inpatient hospital eductible for all inpatient days not subject to the deductible.
- Offering an enhanced Part A benefit as an integral part of the beneficiairies election of Part B. (Part B is optional, although almost all persons elect to obtain the protection).The enhanced benefit would provide for:
  - elimination of the new daily coinsurance on hospital inpatient days;
  - elimination of the coinsurance on skilled nursing faccility stays.
- Offering an enhanced Part B benefit. This would be offered on an optional basis to beneficiaries - not as an integral part of the Part B election. The enhanced benefit would provide a yearly limit on Part B out-of-pocket expenses for the coinsurance and deductible; the limit would be indexed annually.
- Financing of both the expanded portion of the Part B benefit and the enhanced optional Part B benefit through additional Part B premium amounts. It was estimated that an actuarially sound annual premium necessary to finance the enhanced Part A benefit would be $56.50 in 1985; the Council recommended adding an additional $42 per year to generate additional revenue for the Part A trust fund. For the enhanced Part B benefit, it was estimated that if an annual cap of $227 were in place in 1985, an actuarially sound premium would be $150. No portion of the enhanced Part B benefit would be financed through Federal general revenues.

The Council's proposal was intended to meet several objectives including improving catastrophic protection, simplifying the benefit package, incorporating reasonable cost-sharing charges in a manner that discourages overutilization of services, and spreading the risk among all beneficiaries. The design of the benefit package was based on several considerations. With regard to Part A, the Council was concerned that if improvements were financed solely through increased coinsurance charges, the burden would be borne only by users of services rather than all beneficiaries. It felt that a preferable alternative would be to finance a portion of the increased costs through a premium - thereby spreading the risk. However, it wished to assure that no person who contributed through tax contributions during their working years would be denied Part A protection because of the failure or inability to pay a premium. Thus the enhanced Part A benefit, financed by a premium, would be made an integral part of the Part B election.

The Council was also concerned with the out-of-pocket costs associated with Part B benefits and recommended an optional enhanced Part B benefit. It noted that making the Part B enhancement optional might make adverse selection a problem (that is only those who expected to need the protection would purchase it, thereby driving up the costs). However, in view of the coverage of typical Medigap policies, the Council believed the recommended enhancement would be competitive and therefore concluded that a significant portion of the Medicare population would purchase the coverage.

H. Bowen Proposal (November 1985)

Otis Bowen, now Secretary of the Department of Health and Human Services, chaired the 1982 Advisory Council. Subsequently, he coauthored a proposal with Thomas Burke (Executive Director of the Council) which appeared in the Federation of American Hospitals Review (November/December 1985). This proposal (sometimes referred to as the Bowen proposal) built upon the recommendations made by the Advisory Council. Specifically, the authors recommended that an actuarially sound premium be added to Part B which would entitle beneficiaries to the following:

-- coverage for an unlimited number of acute inpatient days;
-- no coinsurance liability for inpatient days;
-- a maximum of two inpatient hospital deductibles per year;
-- elimination of the coinsurance for covered SNF services;and
-- a maximum out-of-pocket cost limit for Part B services.

The authors proposed that the maximum out-of-pocket Part B liability be set at $350 which would result in an annual premium of $145 in FY1985. (They noted that if the catastrophic protection were limited to Part A services, the annual premium would be $36 in FY85.) Bowen and Burke noted that under the proposal, the costs of catastrophic care would be spread over all beneficiaries and suggested that few persons would drop their Part B coverage because of additional premium charges. Since most of the elderly currently purchase private Medigap policies, this proposal would enable them to acquire comparable benefits at a fraction of the costs. They cited several advantages of the proposal including the low administrative costs of Medicare (2.5 percent compared to as much as 50 percent under some Medigap policies); minimal, if any, additional cost due to eligiblity determinations; and simplified record keeping for the elderly. Under the plan the added benefits would be furnished at no additional cost to the Federal Government.

Bowen and Burke addressed the concerns raised in some corners that adding catastrophic coverage would merely increase utilization. While they felt such an effect was unlikely they noted that the proposal could be modified by either limiting the catastrophic protection to Part A services, or alternatively increasing the Part B limit from $350 to a higher amount. The greater the out-of pocket limit, the lower the premium would be for enhanced Part B coverage.

Bowen and Burke also outlined a chronic care plan as phase 2 of their proposal. Under this plan, individuals would be encouraged to establish voluntary individual medical accounts (IMAs). These accounts, similar to individual retirement accounts (IRAs) would be established for insuring against catastrophic chronic care expenses.

I. Pepper Bill (February 1986)

The "Medicare Part C: Catastrophic Health Insurance Act of 1986", introduced by Congressman Pepper and others in the 99th Congress (H.R. 4287, February 28, 1986), would include catastrophic protection as one element of an expanded Medicare benefit package. Under the Pepper bill, beneficiaries (currently entitled to both Part A and Part B benefits) could elect to enroll with an organization such as a health maintenance organization (HMO) which has a contract with the Secretary to provide comprehensive Medicare benefits on a capitated basis, i.e. for a specified predetermined monthly rate per person. At a minimum, the organization would be required to provide the following benefits:

-- Part A and B services without deductibles, coinsurance, restrictions on the number of days of inpatient hospital or SNF services, or a requirement that SNF services be post-hospital;

-- Routine physical checkups;

-- Routine eye care, dental care, and hearing care, subject to certain limitations; and

-- Long-term care services.

Medicare would make capitated payments to organizations in an amount equal to 133 percent of the Adjusted Average Per Capita Cost (AAPCC) determined for health maintenance organizations (HMOs) in the area. (HMOs are currently paid a monthly capitation amount per enrollee equal to 95 percent of the AAPCC.)

The new Part C would be funded through a combination of beneficiary premiums and transfers of amounts that would otherwise have been expended under Parts A and B. Beneficiaries would be required to pay a monthly premium (in addition to the current Part B premium) equal to the amount by which 25 percent of the national average capitated payment rate exceeds the current Part B premium. However, the new premium could in no case exceed 20 percent of the individual's gross income. At the time the proposal was introduced it was estimated that the total beneficiary premium would be $800. States would also be allowed to purchase Part C protection for their Medicaid eligibles.

While H.R.4287 was labelled a catastrophic bill, it essentially offered comprehensive medical benefits (with the exception of presription drugs) to persons who elected to receive their health care services through a specified organization and to pay the requisite premium. No new Federal outlays were estimated by the sponsors. Part C funding would be from current Medicare payments, current Part B premiums, new beneficiary premium payments (which would in many instances substitute for current premium payments for Medicgap policies), and the Federal share of Medicaid payments for long-term care.

J. Harvard Medicare Project (March 1986)

The Harvard Medicare Project, issued its proposal for Medicare reform in March 1986. This proposal represented the culmination of two years of effort by a broad range of persons concerned with the future of Medicare. The proposal included a series of recommendations relating to payments to hospitals and physicians, program financing, and reforms affecting beneficiaries. The proposal envisioned a three-part phase-in schedule.

The proposal included three categories of reforms affecting beneficiaries: changes in cost-sharing, changes in services coverage and program simplification (primarily the combination of Parts A and B). Under the cost-sharing category the plan called for the following changes:

-- Elimination of hospital coinsurance, deductibles for physician care, and balance billed amounts on unassigned physicians' claims;

-- Halving the hospital deductible amount and reducing the Part B coinsurance to 10 percent.

-- Placing an annual $1,000 cap on beneficiary liability for copayments in connection with covered services (under the combined Parts A and B); the cap would be increased annually at the same rate as cost-of-living increases in social security;

-- Establishing a mandatory premium for combined Parts A and B services with the premium amount increased by an additional $150 to $200 per beneficiary to offset reductions in copayments.

The proposal to limit beneficiary liability was thus one element of the cost-sharing reform package recommended by the The Harvard Project. The Project concluded that existing copayments inordinately burden the sick and the poor, are excessive and their unpredictability undermines the principle of insurance. The Project recommended decreasing copayments and increasing premiums. It concluded that premiums are inherently preferable to coinsurance and deductibles because they are predictable, they do not penalize the sick, and they can be related to income. With respect to the latter issue, the Project recommended establishment of uniform standards for Medicaid's payment of Medicare premiums; it was suggested that States be required to purchase Medicare coverage for persons below the 125 percent of the poverty line. Second, the project proposed income tax code changes for persons over 65 with additional revenues earmarked for Medicare (only those elderly who filed tax returns would be affected by this proposal).

The Project proposed the establishment of a public supplemental policy which beneficiaries could purchase on a voluntary basis. The policy would eliminate all but nominal copayments and would be fully financed out of premiums of those electing coverage.

The Project further recommended the levy of a Federal excise tax on private Medigap plans. It has been suggested that persons who purchase such plans have little incentive to limit the use of health services because the financial barriers, i.e. copayments, are covered under the supplemental policies. Most of the increased utilization is paid for by Medicare. The tax levy proposed by the Project was intended to offset the additional cost incurred by the program.

The Project also proposed phasing-in coverage of long-term care services under Medicare. Beneficiaries would be required to pay "residential copayments" (representing room and board expenses) equal to 80% of their social security checks. To further stem overutilization beneficiaries would be required to pay a deductible equal to the cost of one month of care. The Project estimated that the proposed expansion in long-term care and chronic illness coverage would cost an additional $15 billion a year when fully phased-in.

K. Davis/Rowland Plan (1986)

Karen Davis and Diane Rowland ("Medicare Policy: New Directions for Health and Long-Term Care," Johns Hopkins University Press, 1986) have also proposed catastrophic coverage as one component of a redesigned Medicare program. The Davis/Rowland proposal would merge Parts A and B, offer a voluntary long-term care plan as part of the program, and design a separate Medicaid program for Medicare beneficiaries that would provide wrap-around protection for the low-income elderly.

Under the basic Medicare plan, the durational limits for inpatient hospital services would be removed. A ceiling of $1,500 would be placed on all out-of-pocket beneficiary payments in connection with Medicare benefits plus prescription drugs. Current funding sources would be supplemented by an income-related premium payment set at 2.5 percent of taxable income of enrollees up to a maximum of $1,000 annually; a minimum premium of $100 would be established.

The second part of the proposal would offer an optional long-term care plan which would provide coverage for SNF services, ICF services, home health care, and day hospital services. These would be subject to a 10 percent coinsurance charge and have a ceiling on out-of-pocket expenses of $3,000 annually. Optional long-term care coverage would be available for an income-related premium.

The third component of the package, the Medicaid wrap-around plan would cover the cost-sharing under the acute care portion of Medicare for all elderly with incomes below the poverty line. The Federal Government would assume the cost of Medicare acute cost-sharing. Federal support for residual Medicaid long-term care coverage would be reduced.

L. Comparison: Medicare-Related Provisions of Four Selected Catastrophic Insurance Proposals

	Secretary's Report to the President	Bentsen Bill, S. 569 (99th Congress)	Durenberger Bill, S. 1211 (99th Congress)	Dole/Danforth/Domenici Bill, S. 748 (96th Congress)
1. General purpose	The proposal includes recommendations for offering or encouraging the availability of insurance for catastophic health care expenses for both elderly and non-elderly populations. Under Medicare, the proposal would establish a cap on annual out-of-pocket expenditures for Medicare covered services.	The proposal would establish a cap on annual expenditures for Medicare deductible and coinsurance charges, and provide extended coverage for inpatient and SNF care.	The proposal has no Medicare-specific provisions. Rather, it would: (1) require employers who have over 25 employees and who provide a health benefits plan to include in those plans catastrophic expense protection that would be triggered after expenditures of $3,500; (2) amend the Internal Revenue Code to provide a deduction for persons who are not covered under an employer provided health plan (e.g., the self-employed) and who pay premiums for qualified health benefits plans, defined as offering catastrophic coverage; and (3) amend the Internal Revenue Code to place a limit on an employer's contribution toward a health benefits plan which could be excluded from an individual's gross income.	The proposal would provide catastrophic protection to the population as a whole and to Medicare beneficiaries by deleting limitations on benefits, eliminating certain coinsurance charges, and limiting out-of-pocket expenses for Part B services.
2. Hospital benefit	The proposal would cover unlimited inpatient hospital days, eliminate inpatient copayment charges, and eliminate lifetime reserve day limits. Beneficiaries would be liable for the inpatient hospital deductible no more than twice per year.	The proposal would provide for unlimited inpatient hospital days, eliminate inpatient copayment charges, and eliminate lifetime reserve day limits. Beneficiaries would be liable for no more than two inpatient hospital deductibles per year.		The proposal would provide for unlimited inpatient hospital days, eliminate copayment charges but would not limit the number of hospital deductibles in a year.

	Secretary's Report to the President	Bentsen Bill, S. 569 (99th Congress)	Durenberger Bill, S. 1211 (99th Congress)	Dole/Danforth/Domenici Bill, S. 748 (96th Congress)
3. SNF benefit	SNF copayment charges would be eliminated. There would be no change in number of covered SNF days.	The maximum number of covered days in an SNF per spell of illness would be increased from 100 days to 150 days. The SNF copayment charges, currently set at one-eighth of the inpatient hospital deductible, would be set at 15 percent of the average per diem rate for post-hospital extended care services in the region. This coinsurance would apply to the first 10 days of such care. Under current law, the coinsurance amount applies to days after the first 20 days of care.		SNF copayments would be eliminated and there would be no change in number of SNF days.
4. Charges included in catastrophic limit	All Part A and Part B deductible and coinsurance charges.	All Part A and Part B deductible and coinsurance charges.		Part B services as well as certain outpatient prescription drugs listed in a special formulary.
5. Catastrophic limit	$2,000 per year, indexed to medical care inflation.	Under Part A, a specific dollar limit is not specified; rather, a limit on out-of-pocket expenses is created by the limit of no more than two inpatient deductibles per year and by imposing the SNF daily coinsurance on the first 10 days of the stay instead of on days over 20. Under Part B, an optional program would be established that creates a catastrophic limit on deductibles and coinsurance of $1,000 per year. This limit would be increased in future years according to changes in the Medicare Economic Index.		Under Part A, only the hospital deductible charge is retained. For part B services, catastrophic coverage would be triggered when a beneficiary had incurred medical expenses of $5,000 in a year for covered services, or had spent out-of-pocket 20 percent of that amount for these services. This limit would be adjusted annually according to changes in the medical care component of the Consumer Price Index.

	Secretary's Report to the President	Bentsen Bill, S. 569 (99th Congress)	Durenberger Bill, S. 1211 (99th Congress)	Dole/Danforth/Domenici Bill, S. 748 (96th Congress)
6. Financing	Fully financed through an increase in the Part B premium.	The additional Part A benefits are fully financed through the creation of a Part A premium. Beneficiaries who have similar catastrophic benefits through other sources could waive the additional benefits and not pay the premium under Part A. The catastrophic benefit under Part B would be fully financed by premiums paid by enrollees electing the optional coverage.		No financing charges made for Medicare amendments.
7. Long-term care	This proposal does not address the issue of catastrophic costs for long-term care services through amendments to the Medicare program. Instead, it relies on a combination of encouraging tax-deferred personal savings, the development of private sector policies for long-term care insurance and tax incentives for the purchase of such policies.	No provision.		No explicit provision.
a) Services	Not specified.	No provision.		No explicit provision; however, expenditures for certain outpatient drugs necessary for a crippling or life-threatening chronic disease could be counted toward catastrophic limit.
b) Financing	Private sector financing with some favorable tax treatment.	No provision.		No provision.

	Secretary's Report to the President	Bentsen Bill, S. 569 (99th Congress)	Durenberger Bill, S. 1211 (99th Congress)	Dole/Danforth/Domenici Bill, S. 748 (96th Congress)
8. Other provisions	Recommends extending catastrophic protection to the non-elderly population through State mandates, optional catastrophic coverage under employer health plans, and encouraging the formation of State high-risk pools for the uninsurable with subsidized premiums.	Establishes a Commission on Long-term Care Services, appointed by the Secretary, that would conduct a study of how the Medicare program might better provide protection against the catastrophic costs of long-term care.		In addition to Medicare amendments, the bill would (1) require employers to offer catastrophic insurance coverage to full-time employees; (2) establish a residual catastrophic health insurance program for those with no other coverage; and (4) require States to offer Medicaid beneficiaries catastrophic coverage.

The **Chairman**. This committee will come to order.

Mr. Secretary, we are certainly honored to have you here this morning. This is going to be the first of a series of hearings on the question of how the private sector and government might work together to improve protection for vulnerable Americans when they have a catastrophic illness.

I think we all know that the number of individuals who are actually affected, that it is a relatively small percentage. But for those who are affected, it is 100 percent, and for their families it is a situation where you can wipe out a lifetime of savings.

What we are trying to do is find a way to give some peace of mind and some sense of security to those people and their families.

Dr. Bowen, you are to be commended for your leadership in bringing this issue to the attention of the people of the country and I think, in turn, for your perseverance in sticking with the issue, developing a set of recommendations that are going to receive this committee's very closest attention.

Like you, Mr. Secretary, many of us here today have a long history of interest in this particular issue. You may recall that the Finance Committee had hearings on this issue back in 1978 and 1979, and that several proposals were brought out to try to resolve the financial problems that are brought about by catastrophic illness. Senator Long, Senator Dole, Senator Danforth, Senator Baucus, and others, offered a broad range of options for the committee's consideration.

In the last Congress, both Senator Durenberger and I revisited that issue. My bill, as you know, focused on the need to close a number of serious gaps in coverage for the elderly and disabled individuals who participate in the Medicare program.

With his charge to you last evening in his State of the Union address, President Reagan joined in what I hope will be a successful effort to bring together the best elements of each of these proposals in a bipartisan assault on the threat of financial ruin for families who, through no fault of their own, experience a catastrophic illness.

Now, I am well aware that it is not an easy task. While we began with a broadbased enthusiasm and common goal, we still don't have a consensus with respect to such basic issues as the scope of covered benefits, target populations, or how you pay for them.

We face an enormous challenge in attempting to join these views on each of these issues, but face it we must. The American people expect and deserve nothing less than our best effort to construct a genuine safety net for those few situations when existing private and public insurance is just not enough.

While I remain open to suggestions about the elements of the committee bill, or a series of bills, I believe agreement may be within our reach with respect to closing gaps in coverage for the elderly and disabled, who now rely on Medicare as their principal source of health insurance.

More than 28 million elderly people are covered by Medicare today. Last year, 21 million paid $13 billion in premiums for private supplementary insurance; yet, 20 percent remain uncovered by Medicaid or private Medigap policies.

According to actuaries with the Department of Health and Human Services, lack of supplemental insurance means that, while most older Americans have some form of third-party coverage, fully one-fifth of those over the age of 65 are at risk of a financial catastrophe. With health care costs rising at a rate of 7.7 percent in 1986—seven times the increase in the Social Security cost of living adjustment—it is clear we must move ahead to build protection in the current system.

As the committee begins its deliberations, I hope that members will concur that our work should be guided by a handful of basic objectives:

Additional coverage should be provided for persons who require lengthy hospitalization;

Perverse arrangements that place the greatest financial liability on the sickest patients just have to be reformed;

Skilled nursing care and community-based services must be provided for those who require transition care between hospital and home;

Restraints on out-of-pocket expenses should protect the most seriously ill, whose life savings could be quickly exhausted by an unexpected medical catastrophe; and that

These improvements should be financed using the broadest possible base and must not exacerbate an already serious federal deficit.

Mr. Secretary, your guidance and expertise are critical to the success of this undertaking. I look forward to hearing your testimony today and to working with you over the next few months in trying to develop legislative proposals that, when signed into law, will help protect the most vulnerable among us from the financial ruin that can accompany a catastrophic illness.

And now I would like to turn to the ranking member of the minority, Senator Packwood, for any comment he might make.

Senator PACKWOOD. Thank you, Mr. Chairman.

Mr. Secretary, I came to the Senate in 1969. I have been here through Carswell and Haynesworth and the invasion of Cambodia, President Nixon and Watergate, and President Carter's malaise, and now President Reagan and Iran and the Contras. I have seen issues rise and fall. I have seen regional issues; some issues would be of dramatic effect in certain parts of the country and not others.

In those 17 years—18 years now, almost—I have not encountered an issue that engenders as much sympathy and feeling and heartache as the issue of catastrophic health costs, and it is uniform in Oregon or Texas or Missouri, Arkansas, or anyplace else.

I am not sure I know the answer. And the problem is not limited to just the elderly—and by this I don't mean that also there are those who are 30 or 40 who can have catastrophic costs; I am talking about the children of the elderly who wonder how can they afford to take care of their parents when they are making $15-16-17-18,000 a year, and nursing homes cost anyplace from $1250 to $3000 a month.

I hope you have some directions for us. I have read your report, and you come at this with a good heart and good credentials. I wish you luck. I wish us luck, for the sake of the country.

The CHAIRMAN. Thank you very much, Senator Packwood. I know there are others who have strong feelings on this committee on this issue. I would ask that you defer your comment on them now, and we will take your statement for the record, and you can speak up on your questioning period. But because of the limitations of time and having Dr. Bowen here, I would like to have him proceed.

If you will, Dr. Bowen?

STATEMENT OF HON. OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY THOMAS R. BURKE, CHIEF OF STAFF, AND DR. RONALD DOCKSAI, ASSISTANT SECRETARY FOR LEGISLATION

Dr. BOWEN. Good morning, Mr. Chairman and members of the committee.

I am honored by this opportunity to make my first appearance in the 100th Congress on the issue which has been at the top of my agenda, and that is protecting our elderly against the devastating effects of catastrophic health care costs.

The subject for today's hearing is one which I know is of the utmost mutual concern. I commend you, Chairman Bentsen, for your leadership on this issue, and indeed, I applaud the great interest shown thus far by all Finance Committee members. Your work in this issue is very important, since the Committee on Finance has jurisdiction over the Medicare program.

I am hopeful this hearing will mark the onset of an open dialogue, as we work together to find the appropriate private and public sector solutions to a very pressing problem.

Be it through our personal experiences or those of family or friends, we certainly have all seen how a devastating illness can destroy the financial security of a family.

President Reagan deserves the thanks of Americans for recognizing this need. He has been a long-time supporter of catastrophic coverage—first as Governor of California and now as President. Without President Reagan's leadership, I doubt that we would be having these discussions.

That is why the President asked me last February to report options to him on how the private sector and government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when a catastrophic illness strikes.

My report provides a good starting point to begin the debate of how to address the various problems associated with catastrophic health care coverage.

In conducting the study, at the outset we recognized that the catastrophic illness problem is both large and complex. The possible solutions to this problem are numerous, and there is no single policy that will reduce the catastrophic burden for everyone.

Let me highlight what we have been doing in the year since the President asked for a study of this issue:

Many people and organizations contributed to our work. One prong of our efforts was a Private/Public Sector Advisory Committee that I established to actively solicit information from all interested parties throughout the country on their concerns and their ideas to solve the catastrophic health problem.

This committee was chaired by Jim Balog, Vice-Chairman of Drexel-Burnham-Lambert, a major New York investment brokerage firm. We selected a blue-ribbon panel representing a broad spectrum of the American public, including representatives of the aging, physicians, insurers, business, and elected officials from all levels of government.

The committee held eight public forums and heard from over 100 organizations and individuals, and last August the Private/Public Sector Advisory Committee's efforts culminated in its report to me, synthesizing these numerous points of view.

In addition to the Committee's work, the other prong of our efforts was a detailed technical analysis of policy options for catastrophic illness. Department staff consulted technical experts from all over the country to ensure that no major option and no major argument was omitted. All told, over 50 options were analyzed in three technical reports, covering 1600 pages.

There are far too many policy options that were considered to allow full discussion here; however, these are discussed in detail in the report which was provided to you shortly after it was sent to the President.

To understand the catastrophic illness problem, three groups of people must be considered: the elderly facing acute care expenses; the elderly facing long-term care expenses; and the general population under the age of 65.

The chance that a catastrophic illness event will strike a member of these different groups occurs at different rates and frequencies.

Elderly Americans require more medical care than younger persons and are more apt to suffer the consequences of an acute illness or need long-term care.

Of the more than 28 million elderly who are Medicare beneficiaries, approximately 1.2 million will incur personal costs for acute care of $2000 or more in 1987. This can be a heavy burden for those elderly living on $6000 to $7000 in Social Security benefits.

Virtually all elderly have acute care insurance protection under Medicare, and nearly two-thirds also have private supplementary insurance, or Medigap. But there still may be significant gaps in coverage.

As you are aware, Medicare hospital coverage is limited; after 60 days, a Medicare patient begins to make increasingly costly payments. There is also a required 20 percent co-payment for all physician services covered by Medicare.

Medigap insurance helps for the 65 percent of the elderly who buy it, but even with Medigap an individual may face significant out-of-pocket costs. The state-operated Medicaid program may also help with about 13 percent of the elderly, but there are limits on the kinds of services provided.

To improve catastrophic protection for the elderly facing acute care expenses, my report suggested three options: that Medicare be restructured to provide catastrophic protection financed by an actuarially sound additional premium of $4.92 per month; that Medicare be restructured to provide for catastrophic protection with increased cost sharing related to income; and that Medicare be restructured to include catastrophic coverage with increased cost sharing unrelated to income.

Long-term care ranges from informal, unpaid care provided by family and friends to full nursing home care. It is not typically associated with specific diagnoses, but rather the need for assistance in activities necessary for daily living.

There is limited private insurance coverage of long-term care, and the only major Federal program that covers such care is Medicaid, of which eligibility is restricted to low-income or medically indigent patients.

Most long-term care is provided free of charge by relatives and friends. The strong family and community support for the elderly is one of the finest aspects of American life.

But in addition, 1.4 million elderly currently receive care in nursing homes every day. The expense averages $22,000 a year, and these expenses are not covered by Medicare nor are they usually covered by private insurance. Unfortunately, many seniors believe that nursing home expenses are covered by Medicare or Medigap—the truth often comes as a shock—and these individuals find all their savings consumed by a stay in a nursing home.

The urgency of long-term care as a policy problem is increasing as the population ages. Within the next 45 years, the number of people living to age 85 and beyond will quadruple, and by the year 2030, 8.6 million Americans will be over the age of 85, compared with 2.7 million in 1985. These are the people in need of long-term care, and these are the people who should begin now, in their middle age, to make provisions for that care.

Obviously, we need to look far down the road for any approach to long-term care. Changes in the system would be very costly and won't come overnight. Among the report's many options, two approaches which were developed prior to tax reform would have:

Encouraged personal savings for long-term care expenses. One idea we had before enactment of the Tax Reform Act was to consider tax incentives such as individual medical accounts. This could be coupled with insurance and be an effective method, not only for coverage but also for prevention of thousands of Medicaid enrollments;

Encouraged the development of private long-term care insurance. There is clearly a need for more innovative and affordable policies of this type. Again, before enactment of the tax bill, we had considered some approaches using the tax code. The President's tax reform initiative eliminated many of the tax code's incentive features that narrowed the tax base, substituting lower rates for our citizens. With the enactment of tax reform, there are other options being considered that would not narrow the tax base.

An action about which there is widespread agreement, though, is to educate the public about the costs of long-term care and the lack of coverage for those costs under Medicare and Medigap insurance.

The Federal Government can work with private industry and other levels of government to help people understand what is not covered under existing insurance, and to encourage them to make provisions for their future needs.

Finally, I would like to mention catastrophic protection for those people under the age of 65. The majority of non-elderly persons have private insurance coverage, most of which is employment-related and much of which provides solid protection against catastrophic expenses.

A significant amount is also provided by Medicare for those who are disabled, Medicaid for low-income families with dependent children, and other government insurance for members of the armed forces.

It has been estimated that some 30 million people under the age of 65 have no health insurance at all, and 10 million have inadequate coverage for catastrophically high expenses. About three-quarters of the uninsured live in families where an adult is employed all or part of the year.

But how many people under the age of 65 actually incur catastrophic expenses? It is estimated that 28.3 million persons use $5000 or more in health services in a year. Many of those expenses are paid by insurance; however, some 2.8 million people pay $5000 or more in out-of-pocket costs after insurance coverage.

To improve catastrophic protection for the general population, two possible approaches included in the options report would:

First, encourage state innovation and initiative in the management of health programs affecting their residents. Their understanding of the needs and problems of local areas enables states to foster catastrophic health insurance in innovative ways. States and localities could integrate the approach with existing programs for uncompensated care.

For example, states, the level of government traditionally responsible for the regulation of insurance, could consider mandating catastrophic protection in employer-provided insurance, the formation of state risk pools, loan guarantees, health insurance requirements for vehicle registration, and greater flexibility in operating Medicaid programs.

Second, tax deductions for health insurance were considered for all employers who include catastrophic protection in their health plans. As I mentioned, the President's tax reform initiative eliminated many of the tax code's incentive features that narrowed the tax base, substituting lower tax rates for our citizens. With the enactment of tax reform, other options are being considered that would not narrow the tax base.

In closing, let me emphasize that my report put forth a range of options for your consideration—a guideline or starting point for what we expect will be a continuing dialogue with Congress.

We also urge the Congress to proceed with caution. The problem is important, it is complex, and potentially costly to solve. It is important that we not create new problems nor aggravate old problems while solving this one.

In addition, we caution that congressional bills should not displace the private insurance market. To help ensure consideration of costs, we urge the Congress to consult CBO and the Administration to have their options priced and thoroughly worked out between the private and public sectors and between all levels of government, and between insurers and medical providers.

I believe it is possible to craft a proposal within those guidelines, and I believe it is necessary that we do so. I look forward to working with the Congress.

Thank you again for allowing me to present our views on catastrophic health coverage. At this time, I would be pleased to try to respond to any questions you may have.

Before doing that, I would like to state that to my left is Mr. Tom Burke, the Chief of Staff of HHS, and to my right is the Assistant Secretary for Legislation, Dr. Ron Docksai, who will assist me.

[The prepared statement of Dr. Otis R. Bowen follows:]

STATEMENT OF HON. OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES

INTRODUCTION

Good morning Mr. Chairman and members of the committee. I am honored by this opportunity to make my first appearance in the 100th Congress on the issue which has been at the top of my agenda: Protecting our elderly against the devastating effects of catastrophic health care costs.

The subject for today's hearing is one which I know is of the utmost mutual concern. I commend you, Chairman Bentsen, for your leadership on this issue, and indeed, I applaud the great interest shown thus far by all Finance Committee members. Your work on this issue is very important, since the Committee on Finance has jurisdiction over the Medicare Program.

I am hopeful this hearing will mark the outset of an open dialogue, as we work together to find the appropriate private and public sector solutions to a pressing problem.

THE OPTIONS

Be it through our personal experiences, or those of family or friends, we certainly have all seen how a devastating illness can destroy the financial security of a family.

President Reagan deserves the thanks of all Americans for recognizing this need. He has been a long-time supporter of catastrophic coverage—first as Governor of California and now as President. Without President Reagan's leadership, I doubt that we would be having these discussions.

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In conducting the study, at the outset we recognized that the catastrophic illness problem is both large and complex. The possible solutions to this problem are numerous—and there is no single policy that will reduce the catastrophic burden for everyone.

Let me highlight what we have been doing in the year since the President asked for a study of this issue.

Many people and organizations contributed to our work. One prong of our efforts was a Private/Public Sector Advisory Committee I established to actively solicit information from all interested parties throughout the country on their concerns and their ideas to solve the catastrophic health problem.

This committee was chaired by Jim Balog, vice-chairman of Drexel-Burnham-Lambert, a major New York investment brokerage firm. We selected a blue-ribbon panel representing a broad spectrum of the American public, including Representatives of the aging, physicians, insurers, business, and elected officials from all levels of government.

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There are far too many policy options that were considered to allow full discussion here. However, these are discussed in detail in the report which was provided to you shortly after the options were sent to the President.

THE ELDERLY FACING ACUTE EXPENSES

To understand the catastrophic illness problem, three groups of people must be considered: (1) The elderly facing acute care expenses: (2) The elderly facing long-term care expenses: and (3) The general population under the age of 65.

The chance that a catastrophic illness event will strike a member of these different groups occurs at different rates and frequencies.

Elderly Americans require more medical care than younger persons and are more apt to suffer the consequences of an acute illness or need long-term care.

Of the more than 28 million elderly Medicare beneficiaries, approximately 1.4 million will incur personal costs for acute care of $2,000 or more in 1987. This can be a heavy burden for those elderly living on $6,000 to $7,000 in Social Security benefits.

Virtually all elderly have acute care insurance protection under Medicare. Nearly two-thirds also have private supplementary insurance, or Medigap. But there still may be significant gaps in coverage.

As you are aware, Medicare hospital coverage is limited; after 60 days, a Medicare patient begins to make increasingly costly payments. There is also a required 20 percent co-payment for all physician services covered by Medicare.

Medigap, insurance helps for the 65 percent of the elderly who buy it. But even with Medigap, an individual may face significant out-of-pocket costs. The State-operated Medicaid Program may also help with about 13 percent of the elderly, but there are limits on the kinds of services provided.

To improve catastrophic protection for the elderly facing acute care expenses, my report suggested three options: That Medicare be restructured to provide catastrophic protection financed by an actuarially sound additional premium of $4.92 per month; that Medicare be restructured to provide for catastrophic protection with increased cost sharing related to income; and that Medicare be restructured to include catastrophic coverage with increased cost sharing unrelated to income.

THE ELDERLY AND LONG-TERM CARE

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But in addition, 1.4 million elderly currently receive care in nursing homes every day. The expense averages $22,000 a year—these expenses are not covered by Medicare nor are they usually covered by private insurance. Unfortunately, many seniors believe that nursing home expenses are covered by medicare or Medigap—the truth often comes as a shock—and these individuals find all their savings consumed by a stay in a nursing home.

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Obviously, we need to look far down the road for any approach to long-term care. Changes in the system would be very costly, and won't come over night. Among the report's many options, two approaches, which were developed prior to tax reform, would have:

Encouraged personal savings for long-term care expenses.—One idea we had before enactment of the Tax Reform Act was to consider tax incentives, such as individual medical accounts. This could be coupled with insurance and be an effective method, not only for coverage, but also for prevention of thousands of Medicaid enrollments.

Encouraged the development of private long-term care insurance.—There is clearly a need for more innovative and affordable policies of this type. Again, before enactment of the tax bill, we had considered some approaches using the Tax Code. The President's tax reform initiative eliminated many of the Tax Code's incentive features that narrowed the tax base, substituting lower tax rates for our citizens. With the enactment of tax reform there are other options being considered that would not narrow the tax base.

One action about which there is widespread agreement is to:

Educate the public about the costs of long-term care and the lack of coverage for those costs under Medicare and Medigap insurance.

The Federal Government can work with private industry and other levels of government to help people understand what is not covered under existing insurance, and to encourage them to make provisions for their future needs.

THE GENERAL POPULATION

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A significant amount is also provided by Medicare for the disabled, Medicaid for low-income families with dependent children, and other Government insurance for members of the Armed Forces.

It has been estimated that some 30 million people under the age of 65 have no health insurance at all and 10 million have inadequate coverage for catastrophically high expenses. About three-quarters of the uninsured live in families where an adult is employed all or part of the year.

How many people under the age of 65 actually incur catastrophic expenses? It is estimated that 28.3 million persons use $5000 or more in health services in a year. Much of those expenses are paid by insurance; however, some 2.8 million pay $5,000 or more in out-of-pocket costs, after insurance coverage.

To improve catastrophic protection for the general population, two possible approaches included in the options report would:

First, encourage State innovation and initiative in the management of health programs affecting their residents. Their understanding of the needs and problems of local areas enables States to foster catastrophic health insurance in innovative ways. States and localities could integrate the approach with existing programs for uncompensated care.

For example, States, the level of Government traditionally responsible for the regulation of insurance, could consider: Mandating catastrophic protection in employer-provided insurance; formation of State risks pools; loan guarantees; health insurance requirements for vehicle registration; and greater flexibility in operating Medicaid Programs.

Second, tax deducations for health insurance were considered for all employers who include catastrophic protection in their health plans. The President's tax reform initiative eliminated many of the Tax Code's incentive features that narrowed the tax base, substituting lower tax rates for our citizens. With the enactment of tax reform other options are being considered that would not narrow the tax base.

CLOSING

In closing, let me emphasize that my report put forth a range of options for your consideration—a guideline or starting point for what we expect will be a continuing dialogue with Congress.

We also urge the Congress to proceed with caution. The problem is important, complex, and potentially costly to solve. It is important that we not create new problems nor aggravate old problems while solving this one.

In addition, we caution that congressional bills should not displace the private insurance market. To help insure consideration of costs, we urge the Congress to consult CBO and the administration to have their options priced and thoroughly worked out.

Any solution must reflect a partnership between the private and public sectors, between all levels of government, and between insurers and medical providers.

I believe it is possible to craft a proposal within those guidelines, and I believe it is necessary that we do so. I look forward to working with the Congress.

Thank you, again, for allowing me to present our views on catastrophic health coverage. At this time, I would be pleased to respond to any questions you may have.

The CHAIRMAN. Thank you, Dr. Bowen. In a very short statement you stated well the enormity and complexity and difficulty of the problem.

You were talking about the fact that approximately 65 percent of the elderly and the disabled who participate in the Medicare program have some kind of supplementary insurance. Does HHS have some information telling us the scope of that kind of coverage, of the supplementary insurance?

Dr. BOWEN. About 65 percent, as you say, have supplemental insurance or Medigap policies, and by and large they cover medicare deductibles and co-insurances. However many of them also have limits on the number of days which they cover beyond Medicare coverage, and they have limits as to the percent of the daily payment.

The CHAIRMAN. Do you have any feel for the percentage of them that have a catastrophic-illness element to them, a stop-loss feature?

Dr. BOWEN. Again, it depends just a little bit on your definition of "stop-loss." Is it a stop-loss for the patient, or is it a stop-loss for the insurance company?

The CHAIRMAN. No, I am talking about the patient.

Dr. BOWEN. All right. I don't know what the percentage of those individuals are, but I think that Business Week in a January 12 issue stated that only about 130,000 people of Medicare age have true catastrophic coverage. That includes all types of illnesses and not just acute care. That would be one-third of one percent of all of the Medicare eligibles.

The CHAIRMAN. You were talking about the fact that you thought a monthly premium of $4.92 added to the current Part B Medicare premium of $17.90 per month should be sufficient to cover the cost of the additional coverage you believe Medicare should provide.

I can't help but recall that one former President, in advocating a new program, told the Cabinet Officer, "If you go down and tell that bunch in the Congress what it is going to cost, you are fired." So, we always want to look at the back-up figures in arriving at something like that in the way of a number.

Would you provide us for the record the actuarial assumptions that were used in deriving a figure of $4.92?

Dr. BOWEN. Yes, we will supply you with whatever information we have. I can assure you that the actuarial figures were computed by Mr. Guy King, who is HCFA's actuary and who has a very fine reputation. He has gone over the figures time and time again and has reassured us that, even with building in a little increased utilization, the $4.92 would cover it; and, of course, the reason is that you would be spreading it over 30 million people so that it is a true insurance program.

[The information follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the Assistant Secretary
for Legislation
Washington, D.C. 20201

MAR 11 1987

The Honorable Lloyd Bentsen
Chairman
Committee on Finance
Washington, DC 20510

Dear Mr. Chairman:

Pursuant to your request at the January 28 hearing on "Catastrophic Health Insurance", I have enclosed a copy of the methodology used to determine the premium for catastrophic coverage under Medicare.

I hope the enclosed information is useful. If you have questions or need additional information, my staff or myself are readily available to assist you.

Sincerely,

Ronald F. Docksai
Assistant Secretary
for Legislation

Enclosure

METHODOLOGY OF ESTIMATING CATASTROPHIC COVERAGE PREMIUM

To determine the catastrophic coverage premium, a computer model was constructed. The model projects the medical expenditure of each individual in the sample from the base year to the target year. Beneficiary's out-of-pocket liabilities under the present law benefit structure and under the catastrophic coverage proposal were then determined. The difference between these two out-of-pocket laibilities represents the additional cost arising from the new and restructured Medicare benefits. By aggregating the additional costs for all beneficiaries in the sample and then expanding it by the right proportion to represent the entire Medicare population, the total added cost was determined which is to be funded through a premium paid by all enrollees in the Part B program. Such a premium is obtained by dividing the total additional cost by the number of Part B enrollees. Note that the premium so determined is the benefit premium. It does not include any increase in the ongoing administrative expenses associated with the new benefits. Nor does it include any cost needed to set up a new, or to modify the existing data collection and processing system to monitor the restructured benefits.

The data file used is a one percent sample of Medicare enrollees who received benefits in calendar year 1983. It includes records for 196,300 individuals. Each record contains certain demographic information along with utilization data of medical services in 1983, such as number of hospital admissions, number of inpatient days, amount of Part A reimbursement, amount of Part B reimbursement, etc.

In projecting the base year data to the target year, changes in the Medicare program that took effect during or after the base year which had significant impact on reimbursement or utilization were taken into consideration. Time trends in utilization and unit cost of major types of medical services were also reflected in the projection. These adjustments were determined in such a way that in the aggregate the projected values of certain major parameters closely match those in the 1986 Trustees' Report.

Liberalization of benefits always carries the risk of encouraging utilization of services, either because of beneficiaries' own initiatives or because of providers' behavior, especially when beneficiaries' out-of-pocket expenses are near or over the cap. However, trying to estimate the extent of such induced utilization because of behavorial changes is inherently difficult. To compensate the potential of induced utilization, a small margin of five percent was added to the rate.

The final premium for the Bowen proposal was $4.92 a month for calendar year 1987. If the proposal is not implemented until 1988 or later, the premium will be higher.

To illustrate the approach described above, the derivation of the $4.92 monthly premium is presented below.

	1987 projection
1. Number of Part A deductibles under present law	8,156,600
2. Number of inpatient coinsurance days	2,776,200
3. Number of lifetime reserve days	1,057,300
4. Number of SNF coinsurance days	4,901,800
5. Part A out-of-pocket expenses under present law =(1)x520+(2)x130+(3)x260+(4)x65	$5,196 million
6. Part B out-of-pocket expenses under present law	9,228 million
7. Combined out-of-pocket expenses under present law	14,424 million
8. Combined out-of-pocket expenses under catastrophic proposal	12,906 million
9. Reduction in beneficiaries' out-of-pocket expenses (=(7)-(8))	1,518 million
10. Estimated cost for 365-day inpatient benefit	240 million
11. 5% margin	88 million
12. Total net cost (=(9)+(10)+(11))	1,846 million
13. Number of Part B enrollees	31.5 million
14. Net annual premium (=(12)/(13))	$59
15. Net monthly premium (=(14)/12)	$4.92

The CHAIRMAN. Doctor, my experience here is one that leads always to some skepticism on numbers. I helped carry ERISA through this committee, and I recall, when it came to the premium which was to be established per employee, that the actuary stated 50 cents a year would be quite adequate. I said, "Well, why don't we just make sure of that by doubling it?" And we went to a dollar. I am not sure where it is now, but it is quite a multiple of that.

Another question gets into what the American Association for Retired Persons and the National Council of Senior Citizens and others advocate on behalf of the elderly, that a major gap in Medicare coverage concerns the long-term care of a custodial nature. Of course, we are getting into nursing home care.

Then I note that you speak of a figure of $22,000 a year as being the average cost.

Why do you think the incentives are needed that you suggest in the way of tax incentives? Is the private sector not responding to the care and needs of the elderly and disabled? And if not, why?

Dr. BOWEN. It is true that the insurance industry has not come forward with plans for long-term care, but this is not totally their fault. The market simply isn't there, because so many of our senior citizens have the idea that, "This won't happen to me; I don't need this insurance." I believe there needs to be a consumer educational campaign.

We need to have an educational program which tells beneficiaries what Medicare and medigap cover and what Medicare and medigap do not cover. We need then to give them an incentive to enroll in some type of insurance program.

Actually, only about 1.7 percent of total nursing home costs is covered by private insurance. Fifty percent of costs is paid by Medicaid, of the 1.4 million who are in nursing homes every day. The remaining 48.3 percent is paid right out of the pockets of the individuals.

The CHAIRMAN. Dr. Bowen, I see my time has expired The members of this committee will be in and out this morning as they meet their other committee requirements, but their intense interest in this issue is reflected in the attendance you see here.

I would like to cite the arrival time of the order of the members of the committee, and their questioning will be done in that order.

The first to arrive this morning is Senator Heinz, then Packwood, Chafee, Durenberger, Pryor, Danforth, Daschle, and Moynihan.

I would now recognize Senator Heinz for his questions.

Senator HEINZ. Mr. Chairman, thank you very much.

Mr. Secretary, when you made your report to the President in November of last year, you pointed out that there were three big problems, and you have referred to them here: acute catastrophic protection for the elderly, long-term care protection alternatives for the elderly, and catastrophic protection for the general population.

You also mentioned in your testimony today the problem of what some people put as high as 37 million Americans who work for the most part and do not have any health insurance, and who are not eligible for Medicaid.

Now as I understand it, you are not making any proposals on some of the more general problems; but, with respect to the elderly, in November you recommended to the President a specific proposal on elderly catastrophic costs. Today, as I understand it, you are not here to recommend that proposal to us; it is not the Administration's position. Is that right?

Dr. BOWEN. I would have to say that the Administration is still studying it. The President, as he stated last night, will come out in the near future with some recommendations. I, personally, do not know what those recommendations will include, but I have had the opportunity to present my report on several occasions to the Domestic Policy Council, and on two occasions before the President.

I don't know that it has all been ruled out, and I don't know that it has all been accepted.

Senator HEINZ. All right. Are you still urging your original recommendation on the Administration?

Dr. BOWEN. Obviously, being the author of the report, I am prejudiced toward its importance and value. But again, once the President makes his decision as to what the plan should be I am a member of the Administration, and I will support it.

Senator HEINZ. We all understand, but I just want to encourage you to press for what you think is right. I know the kind of man you are, and it would be out of character for you not to do that.

So, let me give you just congratulations and encouragement further to keep doing what you have been doing, and that the Administration come to a conclusion. Obviously, if it isn't the conclusion you want, you are a loyal supporter of the President and you will support the President's final decision. We know that, and we expect that.

Let me ask you about something you said about long-term care. You referred to how, if changes in the Tax Code hadn't been made last year, there were certain things you might have proposed.

Now, one of the criticisms of your recommendation—I can't call it "the Administration's proposal"—is that it doesn't get into the long-term care area at all. And as I understand the rationale for not getting into long-term care from your statement, it is that people who are in middle years now should prepare for the cost of long-term care 30 years or 40 years hence.

Now, I think we all endorse the notion of self-reliance, but there is a difficulty with asking every American to self-insure against the possibility of a long-term care "catastrophic" kind of cost, and that is that people do not know whether they are going to live long enough to become at high risk of contracting one of the diseases that we associate with long-term care—whether it is Alzheimers or rheumatoid arthritis, or any of the very crippling, debilitating, and extremely costly diseases.

My question is, what is the chance of any American today living to age 85?

Dr. BOWEN. What chance is there?

Senator HEINZ. Yes, what is the actuarial chance of an American, who is in his middle years today, 40 to 55, living to age 85?

Dr. BOWEN. The age of life has increased tremendously during this century, I believe from 48 up to the average of 74. So, if we continue with that progression, I think the chance of an individual living longer is good.

Senator HEINZ. But presumably it is less than one in two, isn't it?

Dr. BOWEN. Yes, it is less than one in two.

Senator HEINZ. It might be around one in five, that you might reach age 85 if you are now age 40.

Dr. BOWEN. But in the next generation, the number of persons over age 85 is going to quadruple.

Senator HEINZ. Oh, we don't know. We don't know.

Dr. BOWEN. It is a pretty good prediction, I think.

Senator HEINZ. Would you think that it is going to be better than one in three or one in four? Your statistics are that 8.6 million Americans are going to be age 85 in the year 2030. That leaves out an awful lot of people who didn't make it.

Dr. BOWEN. Right.

Senator HEINZ. You know, your own statistics suggest that the average American isn't going to live to age 85. That is the point of my question.

The point of my question is that you are asking everybody to self-insure against what would be an extremely high cost, and you haven't considered in that population what the incidence of a debilitating illness would be. It is about two in five for anybody who does reach age 85.

My time has expired, but I guess my question is simply that the philosophy of asking every American to self-insure against what can run to $100,000 a year in nursing home bills strikes me as absolutely absurd.

Dr. BOWEN. Well, if you would associate insurance with, say, an individual medical account, then the individual medical account can be used if needed, if not, the money would revert back to the heirs—I think that is a pretty good bargain.

The CHAIRMAN. Thank you very much.

Senator Packwood?

Senator PACKWOOD. Mr. Secretary, you are a very compassionate man and one who has run the spectrum of politics: you have been a Governor, the Speaker of the House, the Secretary of HHS. Let me ask you a question from your personal standpoint and not from the Administration's standpoint:

As a goal, should we be trying to devise a system that would provide against catastrophic costs, whether they be hospital-related or long-term care related?

Dr. BOWEN. I think as a goal, yes.

Senator PACKWOOD. Senator Heinz is correct from the standpoint of the problems of self-insurance. We even saw this in the Individual Retirement Accounts. Try as we might, and attractive as they were, it was the upper-income people that bought them, not the bulk of the poor. They were wonderfully attractive, but they just didn't get around to buying them.

In your statement, you make reference to the fact that perhaps some states could experiment with this, and perhaps even some states who have traditionally been in charge of insurance would mandate at least catastrophic coverage for employees.

I might have bought the argument some years ago about state pre-emption of insurance, but we now have employers and the insurance companies asking Congress to pass a product-liability insurance law and pre-empt the states—not just go along with them, but pre-empt the states.

Why not, at the federal level, mandate this coverage on employers, let them buy the insurance, knowing that in the long run this would be a cheaper way of doing it than the government trying to manage it itself?

Dr. **Bowen**. It is my understanding that insurance is totally regulated by the states; it is a matter of philosophy whether the states should do it or the Federal Government. But as a past Governor, I would be reluctant to give the State control of it up.

Senator **Packwood**. But picture this, Governor, in your capacity as Governor: Comes the Indiana Medical Association to you and says, "Please pass some kind of state-mandated long-term coverage." And in comes the Indiana Association of Manufacturers and the Indiana Chamber of Commerce to say, "That will make us uncompetitive with Illinois and California; you are going to push up our costs. You can't do that. That is something that should be done at the national level." You know that is the answer you are going to get from the employers of your state, and I think this is going to be expensive coverage. In this case they won't be blowing smoke; they will push their costs up.

Given that, why not do it at the federal level? The insurance companies want us to do it in product liability. Many of the states are asking us to do it in product liability insurance. So it is not a question where we are going to be virgins in this.

Dr. **Bowen**. That would have to be a judgment that each and every one of you would make. I have no opinion one way or the other on that.

Senator **Packwood**. Next question: Assuming that you do this even at the state level, what is going to be your key for cost-containment once the nursing homes, if it is long-term care, or the hospitals know that once you have gone beyond a certain level the government, or the insurance company, or whoever is the payor of last resort, is going to pay everything?

Dr. **Bowen**. Certainly that is not in our proposal; everything cannot be paid for by government. I think individual responsibility is extremely important, and that would be one of the arguments I would want to use with Senator Heinz's remark that individuals should be responsible to a great extent for their own future.

Senator **Packwood**. And what happens if they don't? Then they turn into those who are running for office who say I will take care of it, the government will take care of it.

Dr. **Bowen**. That is one of the problems. And certainly, if it were through no fault of their own, then I think the government has some responsibility. If it were through fault of their own, then that would be a different ballgame.

Senator **Packwood**. If it is through no fault of their own, then what? Tough luck?

Dr. **Bowen**. If it were through fault of their own?

Senator PACKWOOD. Yes, through fault of their own, that they should have bought insurance when they were 45 to take care of themselves in a nursing home when they were 75, but they didn't.

Dr. BOWEN. I would have to say that there would have to be some special rules and regulations or laws to take care of those individuals, or to say that it is up to their own friends or relatives to handle the situation.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Dr. Bowen, in your report, on page 87, you discuss allowing individuals below the 125 percent of the poverty line to buy into the Medicaid program. And that seems to make a lot of sense. But the cost of it is very expensive. As you point out, I believe the cost was $15 billion. That is on page 87, where you discuss it.

Now, I don't know how you arrived at that figure or what services were included, but my question is: Couldn't there be a less expensive package that could be provided at a reasonable premium? In other words, I think the idea of buying into the Medicaid program makes some sense.

Dr. BOWEN. Again, I believe this is for the under-65 age group.

Senator CHAFEE. That is right. They are the group that I think we do have to worry about. The accent here has been on the elderly, and we are deeply concerned about them; but I think we have the other group as well who are hit by Alzheimer's or whatever it might be in the family. I am interested in exploring this buying into the Medicaid program that you touch on.

If Mr. Burke wants to address it, that's fine, or anybody.

Dr. BOWEN. I will ask him to do so, but it seems to me that the 125 percent could be adjusted up or down to alter the $15 billion cost if all eligible people enrolled.

Mr. BURKE. This is an option, Senator, where you are looking at the near-poor. The Medicaid program has some pretty strict eligibility criteria—the aged, blind, and disabled. If we could loosen it up for those near the poverty level, but just above the poverty level, where they could buy into the program and get the Medicaid benefit package, it would provide them with some catastrophic coverage that they do not have now.

Senator CHAFEE. Now, in your report you state that half the elderly receiving Medicaid for long-term care services have spent down; in other words, they didn't start out in that situation, but they had to spend down because it is costing them so much, and thus they become eligible for the Medicaid.

My question is: These individuals have ended up on Medicaid because they have had tremendous front-end payments. In other words, a relative from the family was afflicted with Alzheimers and had to go into some kind of a facility, and the family had to spend down a very substantial portion of its assets and end up on Medicaid, or the individual does. My question is, what about, instead of that huge front-end expenditure to cover the $22,000 a year with somebody whose total family income is $16,000, for example, what about some kind of an arrangement where there could be a continual contribution adjusted for income which would keep the family and the spouse out of the poverty level? Do you understand the question?

In other words, take your figure of the $22,000 a year. The family's income is $16,000, and they have a house. Instead of forcing them into poverty where they are not going to be able to pay anything toward the Medicaid after a while, any contribution toward the care—take the Alzheimers, which is the easiest situation to take. Suppose we had some kind of a set-up where we said, "All right, you have an individual from the family with Alzheimers going into a nursing home at $22,000 a year. We are not going to make you spend down into Medicaid, but you will pay $4000 a year toward the care in perpetuity." Does that kind of an arrangement make any sense?

Dr. BOWEN. That is cost-sharing I suspect it would have to be costed out to ascertain the total cost to the government and to the individual himself.

About 40 percent of all of our people have out-of-pocket expenses of under $100 a year, and with that level of expenses you wouldn't worry. But the top 10 percent have out-of-pocket expenses of over $3500 a year, and I think that is the group you are talking about.

With what ever type of plan you have, you are always going to have to draw a line on who is given help, so that there are those who are just under or over the limit.

Mr. BURKE. Senator, let's say they go into a nursing home, and they have Social Security checks coming in which may be $10-12,000 a year. They forego that, and it is transferred to the nursing home. So, I am not sure what you would gain by paying an additional $4000. You are paying all of their Medicaid expenses now, and the income which they have is an offset to that. They are allowed $25 per month for personal expenditures.

Senator CHAFEE. Well, my time is up, but what I am worried about is forcing them down into poverty. That is why we are here, of course.

Dr. BOWEN. About 500,000 a year are forced into poverty and have to go on Medicaid. I believe it only requires around three to four months in a nursing home before Medicaid eligibility occurs, for the average individual.

Senator CHAFEE. Thank you very much, Doctor.

The CHAIRMAN. Thank you, Senator Chafee.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, I thank you for your references in your opening statement to the work that a number of people on this committee have done on the catastrophic in the past. You have been a leader, and I congratulate you for picking this subject to begin the health hearings.

Mr. Secretary, I have said in the past at other hearings that I am back in the same chair I was in in 1979, when I came to the United States Senate. We are also full circle on the issues, because then one of the occupations in the health area was catastrophic, and Dole, Domenici, Danforth, Durenberger—anybody you could find with a "D" on the Republican side—plus "B", Bentsen, and "L" Long, et cetera, were all working on the issue of catastrophic. And I think it was because we recognized something you said earlier, and that was I think in response to John Heinz's question on long-term care.

You said, "Well, the attitude of people was that, "This won't happen to me; I don't need the insurance." That is the problem that we have all faced in this country.

When I came to the workforce, that was my attitude; so, my employer provided insurance for me, because I wouldn't buy insurance out of my cash because I didn't think anything was going to happen to me. Employers started buying insurance for me; therefore, we got a Tax Code protection for insurance and everybody got health insurance, and nobody cared how much it cost to go to a doctor or a hospital anymore, because somebody else was paying the bill.

We didn't buy catastrophic until things got tighter, because catastrophic was the last thing we expected to happen to us. We would protect ourselves for dental or maybe for a broken leg if our kid played football, or as the case may be. But catastrophic was something that we didn't quite get around to.

So, in 1979 this committee was saying, "Hey, look—catastrophic is the cheapest insurance you can buy. Maybe it ought to be the first benefit that we provide."

At that time, Mr. Secretary, one of our suggestions was—and this is a la Senator Packwood's recommendation—one of our suggestions was that we mandate, in exchange for the tax benefits to employers, only one benefit, and that is catastrophic—nothing after that. You don't have to have this, that, the doctor or the hospital, or anything, but one benefit only in exchange for $28 billion a year worth of tax subsidy, and that is that you provide in that package catastrophic.

Now, what is wrong with that theory?

Dr. **Bowen**. Again, it is one of the options that is available, and I think it has a lot of good points. It depends on where you draw the line and say, "This is catastrophic, and this isn't." What is catastrophic to one individual may not be catastrophic to another. So I think you would have to test it in some way according to people's income.

Senator **Durenberger**. But it is worth exploring?

Dr. **Bowen**. It is definitely worth exploring.

Senator **Durenberger**. Can you get any support for it from within the Administration, do you know? Have you tried? Or within the rest of the Administration?

Dr. **Bowen**. I have not pursued that, no.

Senator **Durenberger**. Let me then ask about the next generation. If we could do that, that would take care of me when I retired—so to speak—now, let's talk about my folks who are already retired. They no longer view this as "something that won't happen to me, and therefore I don't need insurance." Sixty-five percent of the people my parents 'age are buying protection because they think it will happen to them. Even though it won't in many cases, with a few exceptions, it is not going to happen to a lot of elderly, but they think it is going to happen to them, and they haven't the capacity to earn income after they have retired to cover themselves.

Now we are at the problem of the elderly, and I wish you would share with us some of the concerns that the rest of the Administration has for your proposal.

I represented the Senate on your task force on catastrophic, and so I know to some degree what you have struggled with to come up with your own recommendation, and that your own recommendation is probably short of what you ideally would actually be recommending.

Now, the rest of the Administration seems to be pulling you back even farther. I am wondering if you could share with us, say in principle, where they are coming from?

It looks to me like the Chairman of the Council of Economic Advisors is the chief advisor to the President now on the subject of catastrophic health insurance. So is the Attorney General. I don't know what either one of them have to do with the subject, but they seem to be the chief advisers. What principles are they operating off of? Would one of them be that if you provide catastrophic, that is an open invitation to over-utilization? Is that one of them? If so, what is the demonstrable proof that that can't be prevented? Do you get my point?

Dr **Bowen**. Yes. I don't think there is any secret, because it has been in the papers. I would like to just recite essentially what has been stated there.

Senator **Durenberger**. Maybe you can tell us a few things that weren't in the papers, too.

Dr. **Bowen**. The fear is that a $4.92 premium would not remain $4.92, and surely it will not remain $4.92 if you index it. We have recommended indexing it so that it would remain budget neutral. They fear it would not remain a pay-as-you-go plan.

We have stated that we have many cost-containment features in the program now. One is the Gramm-Rudman-Hollings requirement, and one is the DRG system. Other cost containment features are our peer-review system, and the capilation systems we are moving toward that would help hold costs down; also there is the fact that the $4.92 premium and the $2000 cap would be indexed.

There is also a fear about removing something from the private sector, and that is a legitimate fear. I don't want to remove business from the private sector that should not be removed, but I don't believe that what we have proposed would do that. I think it would help to stimulate further production of insurance programs and policies. The $2000 upper limit would still be there for which individuals could insure.

The things that Medicare has never paid for—for example, eye care, dental care, and drugs—could still be insured; plus, it would be only natural, then, to slide into long-term care coverage.

The other problem is with our proposals for individual medical accounts, and it is a legitimate concern: that it would reduce income to the Federal Government. But again, my counter-reaction to that is that long-term savings certainly are a boon to the economy. Also, the fact that the combination of an IMA with insurance—and I would like to discuss that with you and draw you a little chart on it sometime—would prevent a lot of people from going onto Medicaid, and that is a long-term savings.

So, there are two sides to the issue, and I certainly honor their opinion, and they have listened to mine. That is where we are.

The **CHAIRMAN**. That was a good line of questioning, and, Dr. Bowen, I am sure you could go on at length with that, but we have quite a number of Senators who have questions that concern them.

Senator Pryor?

Senator **PRYOR**. Thank you, Mr. Chairman.

Mr. Secretary, this question relates to an area called "spousal impoverishment," and we are hearing more and more cases of elderly couples who are forced now to divorce one another, actually go into a court and get a divorce, in order that one of the spouses would be eligible for Medicaid nursing home care, and the spouse left in the community won't be totally destitute.

This is a tragic area, a tragic gap in the wall, and I think this is something that many of us in the Senate and on this committee are concerned with.

I am wondering if your advisory panel or if you and your people are looking into this particular area of spousal impoverishment.

Dr. **BOWEN**. In all honesty, I don't remember that specific topic coming up, but I do recognize that it is a problem. It is being discussed in states right now, that is, what belongs to the spouse after a separation. I know that in our State of Indiana, it is one of our hottest issues this year.

Senator **PRYOR**. Mr. Chairman, a personal note if I might. Former Governor Bowen and I served together as governors of our respective states of Indiana and Arkansas, and I would just like to echo what Senator Packwood and others have said about his record and about his willingness to take on tough issues.

I would like to throw you a little bouquet this morning for really taking on a true issue of major proportions in this country. It is an issue that many of us associate with the elderly, and all of us are concerned with the elderly; however, the issue of catastrophic coverage or catastrophic illness, as you know Mr. Secretary, is not totally an elderly problem. In fact, that 35 million individuals under the age of 65 have no insurance at all in this country—no private, no insurance company has written any kind of a policy on them. And I think this is a concern that many of us have had.

I know that in my own family we have had some personal experience with this just in the last few months, in a very catastrophic situation.

And I also ask the question: Has your advisory group looked into any possible incentives—to the private sector or to the federal sector, or to the Federal Government—an incentive to encourage insurance on a broader base than we have now for more individuals?

Dr. **BOWEN**. We have recommended in our report that we work with the states to do several things. States can be very innovative in trying to get to the uninsured or the under-insured. One of our proposals would have states require that employers offer catastrophic-type coverage.

Also, a state could recommend such things as insisting on adequate coverage for medical expenses, catastrophic included, for motor vehicle registration. This would reach a lot of those who are uninsured medically and whose lack of insurance causes some of the uncompensated care problem.

States could recommend such things as guaranteed loans, for, example, for somebody who is 30 years old and works in a bank, has a pretty good income but has a baby that is a pound and a half who is in intensive neonatal care for three months at $1000 a day. The individual can't pay for it all now, but he or she could over time.

Then, the formation of risk pools for those who are medically uninsurable. I think 10 states already have that type of a program.

These are some of the innovative things that I think states could do, and I think our Department and the Federal Government could work with them to stimulate more of these initiatives.

Senator **Pryor**. Mr. Secretary, my third area of concern is this: Especially in the last year, we have seen many companies coming forward advertising Medigap insurance.

Maybe I have been snowed in lately and have watched an inordinate amount of television, Mr. Chairman, but it seems like all the old great stars are coming on TV these days telling our elderly people, "You need our particular insurance policy to protect you from catastrophic illness."

Now, we are appealing today to a very vulnerable part of the American population, part of the population that is living in absolute fear of what to do next and what could happen to them.

I am wondering if within HHS—and this is my final question—there is any sort of a monitoring program you have to look at some of these policies? Do you have a sort of consumer advocate's office there that advises elderly people when they call about a particular point that they might see on television or hear on the radio or see in the newspaper?

Mr. **Burke**. We are required under the Baucus Amendment to submit to Congress, every two years I believe, a report on Medigap. The report is overdue; it is currently in our clearance process.

This year's report will have some recommendations. We have asked our Inspector General to look at the report and comment on it. He has also spoken to the General Accounting Office, which at the request of Congressman Stark, issued a report last November, I believe. And our Inspector General is working with them to look at their data, and we hope the report may in fact have some recommendations in it along these lines.

That is our only vehicle for overseeing this industry, because, as you know, states oversee insurance.

Senator **Pryor**. Thank you.

Dr. **Bowen**. The GAO has issued a report concerning Medigap, and we have been looking it over carefully.

As Mr. Burke said, our Inspector General is looking over the report and also looking into the problem. I would mention that one of the improvements in the Medigap industry has been the Baucus Amendments that were put in place in 1980. This does give some good guidelines, and there has been some improvement since then.

But again, there is not a lot of teeth in the Baucus Amendments, because they are just reporting requirements, rather than any follow-up; the states are responsible for that, Senator.

Senator **Pryor**. Thank you, Mr. Secretary.

The **Chairman**. Thank you very much, Dr. Bowen.

Knowing the competing demands for the time of the members of the committee, let me review again the order of questioning: Senators Danforth, Daschle, Rockefeller, Moynihan, Wallop, and Mitchell.

Senator Danforth?

Senator **Danforth**. Thank you, Mr. Chairman.

Mr. Secretary, clearly this is going to be a year of intense activity in the Congress to address the catastrophic health care problem. A number of us have been working with this for years, recognizing the tragedy for individuals and families who are threatened by being wiped out by unexpected health care costs. You have broken the problem down into three areas, two of them relating to the elderly—acute care for the elderly and long-term care for the elderly—and then a third category of being the rest of the population.

Correct me if I am wrong. I take it that by "acute care for the elderly" you mean hospitalization, relatively expensive intensive care, sometimes heroic efforts to provide health care for people in hospitals. Is that correct?

Dr. **Bowen**. That is correct. It is usually those who are in longer than what the Medicare program allows for. Admittedly, that is a small percentage; I believe it is about three percent that are vulnerable.

Senator **Danforth**. About three percent of whom?

Dr. **Bowen**. All of the elderly.

Senator **Danforth**. Three percent of the elderly.

Dr. **Bowen**. But that doesn't keep the other 97 percent from worrying about their finances, their health, which will run out first. That three percent represents many people whose savings can be wiped out.

Senator **Danforth**. And then, the long term, the people who would be under the category of "long-term catastrophic," that would be people who don't have an acute medical problem but who are residents in nursing homes, they need some sort of custodial care? Is that correct?

Dr. **Bowen**. That is correct. I suspect the majority of those are Alzheimers and stroke victims.

Senator **Danforth**. Would that be a much greater number than the acute care people?

Dr. **Bowen**. It would be much greater, right.

Senator **Danforth**. Much greater. Do you have a percentage on that group?

Dr. **Bowen**. I think about five percent of the population are at risk for being admitted into a nursing home. For every one who is in a nursing home, there are four others out there that could be, but are being cared for by family and friends. This is something we desire to maintain.

Senator **Danforth**. Keep them cared for in their own homes?

Dr. **Bowen**. If at all possible, yes.

Senator **Danforth**. Is there a possibility that the design of a catastrophic health care plan would increase the number that would be cared for in a nursing home, as opposed to those who would be cared for by their families?

Dr. **Bowen**. I suppose that is a danger, but I think the desire of the individual and of the family would be to keep the individual at home if it is at all possible for the family to take care of them. And I think that would be a big reason why the increase would not be great. But yes, I think if coverage were complete, there would be the risk of increased utilization.

Senator **Danforth**. And then, under the category of the rest of the population, are a lot of the patients within that category infants in the early months of life who are cared for—premature infants?

Dr. **Bowen**. Of course, this would include all people up to the age of 65. One of the most expensive things that can happen to an individual would be, as you say, to have a premature infant who is in a neonatal care center, oftentimes at $1000 to $1400 a day for several months.

Others would be burn victims, for example, who are in for long periods of time, and heart patients, transplants, and so forth.

Senator **Danforth**. Among these three different categories, acute care and long-term care for the elderly and then everyone else in the population, do you have a view as to the relative difficulty and relative expense of us, the government, doing something meaningful to address this problem? Which of these three areas would be easiest? I mean, none of it is easy to get our handle on, but which would be the easiest, do you think?

Dr. **Bowen**. In my judgment it would be the long-term care, simply because the average cost of a nursing home today is about $22,000 per year. And if there are as many—well, I will just stop there.

Senator **Danforth**. Okay. Now, your trigger for what constitutes "catastrophic," for catastrophic coverage purposes, is a fixed dollar amount, $2000 a year?

Dr. **Bowen**. That is for acute catastrophic care.

Senator **Danforth**. Only for acute?

Dr. **Bowen**. That is only for acute care, that's right.

Senator **Danforth**. Would it make sense to have that figure be adjustable according to the income of the family? In other words, $2000 for a very well-to-do family is not catastrophic; $2000 for an impoverished family is catastrophic. Would it make sense to have some sort of income test for what constitutes "a catastrophic illness"?

Dr. **Bowen**. That is an option, and we do have it in our report, as one of the alternatives. That is a type of means-testing.

And you are so right—what is catastrophic to one individual is not catastrophic to another. It would make the administration of the program much much more difficult, but I guess nothing is impossible these days.

Senator **Danforth**. Thank you.

The **Chairman**. Thank you very much, Senator Danforth.

Senator Daschle?

Senator **Daschle**. Thank you, Mr. Chairman.

I was very interested in Senator Danforth's line of questioning, because it was similar to questions I was intending to ask.

With regard to the definition of "catastrophic," you mentioned the $2000 figure for acute care. Could you elaborate? What in terms of long-term care, and how does that relate to the so-called "other group" that you were defining with Senator Danforth?

Dr. **Bowen**. I am not sure I understand what you are getting at, Senator.

Senator **Daschle**. You said that for purposes of your definition, in the area of acute care anything exceeding $2000 was considered "catastrophic." Am I correct?

Dr. **Bowen**. Yes.

Senator **Daschle**. And in terms of long care, what is the figure that you would fix to a "catastrophic" definition?

Dr. **Bowen**. We have not affixed any figure for catastrophic long-term care.

Senator **Daschle**. For purposes of legislation, then, what would you suggest to this committee with regard to how we would define it?

Dr. **Bowen**. Well, it would depend on whether or not you would want to account for income, and I think that would have to be a choice here.

Senator **Daschle**. Well, what is your specific thought on that?

Dr. **Bowen**. Well, we have set it for $2000 for the acute catastrophic care, but realizing, again, that it is one of the things that you can adjust up or down, and can choose to include in it long-term care.

Senator **Daschle**. Have you taken a position personally, Dr. Bowen, with regard to how one defines "catastrophic care" for long-term purposes?

Dr. **Bowen**. No, we have not.

Senator **Daschle**. Do you intend to?

Dr. **Bowen**. All I can say is that we will study it.

Senator **Daschle**. As you analyze the situation with regard to catastrophic illness across the board, Senator Danforth was asking how catastrophic illness relates to the various groups that you have provided in your definition of these kinds of illnesses. In terms of percentages, has HHS done any analysis with regard to the breakdown of catastrophic illness in terms of long-term care, in terms of acute care, in terms of other groups? How does it all fit in the pie?

Mr. **Burke**. I think, Senator, you first have to define what you mean by "catastrophic".

Senator **Daschle**. That is why I was asking the definition at first.

Mr. **Burke**. The number that we took, the $2000 cap, is in fact a flexible number; it has an impact on different people differently. It is not $2000 in expenses for every individual. The $2000 is out of pocket, which means you could have incurred medical expenses of anywhere from $6000 to $10,000, because Medicare requires the 20 percent co-pay, and there are also incurred out-of-pocket expenses that are not included in the cap, for example eye care and drug care. So the $2000 out of pocket cap is somewhat of an arbitrary number, in a sense, but it is in fact a higher number than what it first appears to be.

On the long-term care side of the ledger, I would think if you wanted to define a catastrophic number, you would have to link it somehow to income, because you would have to define "catastrophic" as a function of one's income and resources. We have not done that, and it is not one of the options considered in our report.

Senator **Daschle**. My purpose in asking the question is that I obviously haven't had the benefit of some of your work so far and is in analyzing just how you see the problem.

But clearly, you see the problem as more severe in terms of long-term care than you do of, say, prenatal care, or acute care among other groups of perhaps in my age category. In providing your recommendations, you are making some assumptions that I wish I had before me, because it is unclear, it seems to me, for purposes of catastrophic care, that it is more important to provide assistance to those over the age of 65 than it is for a young family who has just suffered through a severe catastrophic illness for which your plan would have no special attention. Is that correct?

Dr. **Bowen**. That is why we have broken it down into three separate groups. Our studies show that there are different groups with different problems, depending primarily on age. The same solutions are not going to work for all people.

The solution for long-term care is far different than the solution for the under age 65 group.

Senator **Daschle**. Perhaps, then, I misunderstood; but are you not advocating a program primarily for long-term care and not for the other?

Dr. **Bowen**. No. We have them broken down into three separate parts, and we have recommendations for each of these three groups. They are totally different.

Senator **Daschle**. You are suggesting that the legislation take all three of those groups in an equal fashion, in terms of addressing it for legislative purposes?

Dr. **Bowen**. Almost three separate subject matters, really.

Senator **Daschle**. Thank you.

Senator **Packwood**. Senator Mitchell, I believe. Did Senator Rockefeller come before Senator Mitchell?

Senator **Rockefeller**. Thank you, Mr. Chairman.

Dr. Bowen, first let me say that I had the honor to serve when we were both governors, and I admired you then and I admire you now.

Dr. **Bowen**. I remember the miners strikes in both of our states.

Senator **Rockefeller**. One observation, triggered by what Senator Pryor had to say, is the question of confusion with the elderly. Not only is the Medigap matter enormously confusing to the elderly—and I think that is very clear—but this Jimmy Roosevelt Commission for Social Security.

Every week I get checks for $10 bills in my office here in the Senate asking me to send it on to the Commission for Social Security, to protect Social Security, which is for Jimmy Roosevelt's committee. The people hear the name Jimmy Roosevelt, and they think, "Well, that must be correct; Social Security most be in trouble. So I am going to send money." And I think it is one of the great ripoffs of seniors in our country.

I say that only because I hope, when all of this process is through, that we will be very clear—that our guidelines will be clear, and the communication with seniors and those who are not yet seniors about catastrophic illness and what we are going to do about it are clear, are made cohesive and understandable. I don't ask for an answer on that, but I think it is something that is very important.

Within the long-term care business, obviously home health care is a factor. There are figures which indicate that the average Medicare home visit costs about $42, or at least did in 1984, but a day of nursing care in a nursing facility might be $72, and a day in the hospital might be $300. So, there appear to be clear advantages, at least financially, for home health care as part of the addressing of this long-term health care problem.

Now, there is a problem within home health care relating to this thing called "intermittent care," and that is, if after two or three weeks of getting home health care a doctor does not see a declining need for service, then the beneficiary is made ineligible for home health care, in which case that patient may have to go off to a nursing home that may have to be paid for by government funds, all of which seems to me to be counterlogical and certainly more costly to the Federal Government.

Can I ask you, Dr. Bowen, whether or not this home health care matter is important, in your judgement, as an alternative for the long-term health care problem?

Dr. **Bowen**. I think there is no question that the patient should be taken care of in the least restrictive environment, but making sure the quality of care remains there is important. Home care can be less expensive. We have recognized this in Medicaid; we have established what we call "home and community-based waivers" for Medicaid, giving the states the opportunity to use home care rather than institutionalization.

Further, Dr. William Roper, who is the administrator of HCFA, and his staff have met with the home health care industry just in the last two weeks, and they are exploring ways to increase and improve home health care.

We are also doing a special study on that. We expect to finish it within a year.

Senator **Rockefeller**. People in West Virginia—social workers and nurses and others—tell me it makes so much difference to people, getting care in their home, seniors getting care in their home.

I have been in many of those homes, and it is all the difference in the world. But the money for that seems to be declining. The opportunities aren't there, and the priorities aren't there. I think that is one of the reasons that some of us are looking really very seriously at home health care as a cheaper alternative for the expenditure of government funds.

Dr. Bowen, would you make available to this committee any numbers that you might have as to those people who, because of the so-called "intermittent" definition under home health care, have to get out of the home and be put into institutional care, which perhaps could be more expensive to the Federal Government? Could you make figures like that available to us, if you have them?

Dr. **Bowen**. If we have them, I assure you that they will be made available, and Dr. Docksai will be working with your staff to obtain those, if you want.

Senator **Rockefeller**. One final question, Mr. Chairman.

The White House memorandum just prior to the President's speech last night, attached to the speech, basically said that any catastrophic illness coverage should be voluntary, not a new government entitlement, and that the proposal must be budget-neutral without the explosive potential of program expansion.

Dr. Bowen, I don't mean to put you on the spot, but isn't it really quite impossible for us to be discussing catastrophic health care and making it better in this country in its variety of forms without at least some form of budget implication?

Mr. **Burke**. Senator, in the report, the recommended option of $4.92 a month would be added to the Part B premium. The Part B program of Medicare, as you know, is optional. So, in that sense it is optional.

The other statement you made about the need for budget neutrality is certainly also true. I don't think people seek catastrophic care. I don't think you are going to get a natural explosion of utilization, since it is unlikely the elderly would "line up" outside of the hospital to get in for their 150th day of coverage. This sort of thing has its own constraint on utilization, and we are not likely to see explosive utilization that we would see in other areas such as the one you mentioned, home health care, which is the fastest growing component of the Medicare program today.

Senator **Rockefeller**. Yes, I understand that, and I understand also the problem of people coming out of the woodwork, too, for example, with home health care. I understand that has implications.

Dr. Bowen, I just think you have triggered something really important in this country, and you are a breath of fresh air as far as a lot of us are concerned. I look forward to working with you to make this work for our people.

Dr. **Bowen**. Thank you.

Senator **Rockefeller**. Thank you, Mr. Chairman.

The **Chairman**. I must say I am impressed with the very serious line of questioning, Doctor, that you are being subjected to. It shows the deep interest of the members of this committee.

The next person will be Senator Mitchell.

Senator **Mitchell**. Thank you, Mr. Chairman.

I have a statement which I would like to ask be submitted for the record.

The **Chairman**. Of course, without objection.

Senator **Mitchell**. Dr. Bowen, I commend you very much for what you are doing. It is regrettable that you have so little support within the Administration. You will find a great deal more support in the Congress in this area.

But without meaning to diminish what you are doing—it is very important—I think it is significant that your principal proposals deal with what are the smallest part of the problem.

On page 5 of your statement, you divide the catastrophic illness problem into three groups: First, the elderly facing acute care; second, the elderly facing long-term care; and third, the general population under the age of 65.

It ought to be made clear and emphasized that the second group, the elderly facing long-term care, that comprises 80 percent of the total cost of catastrophic expenses for the first two categories—that is, the elderly—and somewhere in between a half and three-fourths of the total cost of catastrophic expense for all three categories. And yet, that is the one area that is pretty much ignored in your proposal.

While your proposal regarding acute care, and that goes to Part A and Part B and goes to the first category—it is commendable, and we have to do something in that area and will do something—it ought to be noted and the American people ought to be made aware that that is a minor part of the problem. The biggest expense is in the second category. And the only thing offered there is so-called "individual medical attention."

Now, the fact is that Individual Retirement Accounts simply were not utilized by the persons who will be most in need here—that is, persons of low and lower-middle incomes. If memory serves me correctly, only about 10 percent of taxpaying units, families with incomes below $30,000 a year, use IRA. The obvious reason is they didn't set aside money for retirement because they didn't have money to meet their current living expenses.

My question to you is: What evidence is there to suggest that, even if Congress were to create Individual Medical Accounts, that any large numbers of families with incomes below $30,000 a year would utilize them?

Dr. Bowen. I don't think there is any way of knowing how many, but I am certain that there would be some. Any number would certainly be an improvement.

We have to remember, also, that the Federal Government is already paying a large portion of the long-term care bill. I think 40 percent of all Medicaid funds go to nursing homes, and 50 percent of all nursing home payments are from Medicaid itself.

But I think you are right; our recommendations on acute care have garnered the most attention; but that is through no fault of ours. We have treated them equally in our attempt to solve the problem. I guess it is because we recommended adding an extra premium and creating an expansion of an entitlement program that it has received the most attention.

But I would like to draw attention to the fact that we also recommended in our report that somebody at the age of 55, purchasing a catastrophic coverage plan, should receive tax preference. But again, as a result of the tax changes, that may not be the option that many of you may like, because it would tend to reduce income to the government in the future. But it is still an option.

Senator Mitchell. Let me just point out, on that point, that Senator Rockefeller pointed out that the President last night, not in his oral statement but in his detailed submission, said that it has to be budget-neutral. An Individual Medical Account would be budget-neutral only if no American used it. To the extent that Americans use it, it violates the principle laid down by the Administration.

Thus, it is clear that your proposal is inconsistent with the President's guidelines. I don't think you are wrong, I think the guidelines are wrong; I want to make that clear. As I said, I think you have done a very good job.

But it seems to me we have got to get at what really is the heart of the problem, 80 percent of the problem with respect to elderly, and a substantial majority of the total problem. That hasn't been done, and I ask you if you would devote your energy and effort to coming up with what I would hope would be a more meaningful and substantial proposal in that important area?

We are going to pursue that vigorously here in this committee, and I know the House will as well.

Dr. **Bowen**. We will have it, obviously, as a continuing study and, as I stated in my remarks, I will be happy to work with the Congress and the Administration to see if we can't come to some solution for this very, very serious problem.

Senator **Mitchell**. Well, I thank you very much, Doctor. Thank you for your testimony, and we do look forward to working with you on that.

Dr. **Bowen**. Thank you very much, Senator Mitchell.

Senator **Bradley**. Dr. Bowen, if you could, try to answer the question in part as a doctor, and in part also as a government official.

We have put in the DRG's in order to improve the efficiency of the Health Care Delivery System. They are beginning to do that; hospitals are now cost-sensitive in a way that they have never been before.

The effect of the DRG's, particularly in this period of transition, is also to put people out of hospitals sooner than they would have been in the past. And prospectively, this will be the case more and more. And there will be mistakes.

It seems to me that in this kind of environment there is an even greater need for home care coverage, don't you agree?

Dr. **Bowen**. In my judgment, there is always a need for home care coverage, because it is the most desirable for the patient, because it is the least restrictive type of care, and because patients like it better.

Senator **Bradley**. Well, would you support legislation that expands home care services, that Medicare will cover?

Dr. **Bowen**. Providing we could make sure that the quality of home care remains comparable to what they could have gotten otherwise.

Senator **Bradley**. And how do we assess whether the quality of care would be comparable?

Dr. **Bowen**. We have in place our Peer Review Organizations who are reviewing essentially all of the elements of care, to make sure that it was proper, to make sure that it was indicated, to make sure that the payments were proper and that admissions were proper, and that their releases were proper.

I think that the biggest element of quality is in the physician him or herself. Being a physician, I suppose I could be accused of being prejudiced, but I think they do want to provide quality care.

Senator **Bradley**. Is quality your only concern, though?

Dr. **Bowen**. Well, cost certainly has to be a concern, but it would be secondary to quality.

Senator **Bradley**. Well, let me give you an example: An elderly citizen that I know in his late eighties recently fell and broke his hip. Now, the hospital said that he had to have an operation. They said, "You can stay in here x-number of days and no longer."

Now, at the end of those x-number of days he had to start paying $3-400 a day, or leave the hospital. There was no way that he could have maintained himself outside of the hospital—no way—without home care.

Now, this is duplicated in circumstance after circumstance after circumstance, and it seems to me that there is a strong case for expanded Medicare coverage for home care. And the only way to determine quality and cost is if you push the home care services outward and Medicare to cover the cost. Don't you agree?

Dr. **Bowen**. Yes, I think that is a true statement.

Senator **Bradley**. Well, specifically, you know the Medicare covers home care when the elderly person is home bound and when the care is intermittent. And I will be interested to see the statistics that you give Senator Rockefeller on that.

But the fact of the matter is, some people are getting Medicare coverage where neither one of those things apply, and yet they clearly need home care. The elderly person I am talking about wouldn't have qualified but clearly needed home care.

So my question to you is, don't you think that we need to expand the Medicare guidelines, specifically?

Dr. **Bowen**. We are having studies performed right now on the subjects of quality and utilization, and I think the subject you brought up with respect to home care should be a part of that study.

Senator **Bradley**. Have there been studies done in the past by HCFA?

Dr. **Bowen**. On your specific issue?

Senator **Bradley**. Yes, on cost-effectiveness of home care?

Dr. **Bowen**. I have not seen them, if there have been any.

Senator **Bradley**. Well, they have been studying them for about three years, during which time they have attempted to stop any move in the committee to do anything on home health care coverage for the elderly under Medicare. So, I really hope that you will get us the results of your studies.

Dr. **Bowen**. Okay.

Senator **Bradley**. And I am pleased that you support the idea.

Let me ask you one other question as a physician: Do you agree with Dr. Koop on smoking?

Dr. **Bowen**. Sure. I think smoking is very, very unhealthy.

Senator **Bradley**. What do you support to curtail smoking in the country?

Dr. **Bowen**. Pardon?

Senator **Bradley**. What do you specifically support to curtail smoking in the country, so that we can reduce what Medicare has to pay for heart disease and cancer and emphysema?

Dr. **Bowen**. Educational efforts that continue to tell the harmful effects of smoking are important. This is especially true as we deal with our young people, because it has been shown that the younger you start smoking, the more apt you are to continue. I think this is a fertile area in which to do education.

Senator **Bradley**. Would you support an increase in the cigarette tax?

Dr. **Bowen**. If you will look back in the report that we put out in 1983 when I was Chairman of the Advisory Council, we did support an increase in the cigarette tax to support the sagging income for Medicare.

Senator **Bradley**. A kind of education. So, you would support an increase in the cigarette tax? To 32 cents?

Dr. **Bowen**. I don't think I am prepared to answer a statement like that.

Senator **Bradley**. But you would like to see it go up.

Would you support a disallowance of the deduction for advertising expenses for tobacco companies to lure these young people you are so concerned about into the consumption of tobacco, which will shorten their lives?

Dr. **Bowen**. I should simply say that we shall enforce whatever law you pass.

Senator **Bradley**. So, you basically are copping out? [Laughter].

Dr. **Bowen**. No, I don't think so.

Senator **Bradley**. Well, my time is up. At least we got you on record for a tax increase.

Senator Riegle?

Senator **Riegle**. Thank you, Mr. Chairman.

I want to say to the witness that I am pleased to have you here this morning. I had the Security Subcommittee upstairs in the Banking Committee, and we have been deeply involved in the hearing today on the subject of corporate takeovers. So, I would have been here earlier but for the need to be present at that hearing.

I want to say at the outset that I personally appreciate the leadership you have shown on this issue and the fact that you have taken hold of it and helped bring it forward, helped focus the debate both in the country and within the Administration within the Cabinet.

When did you get started on this? The President mentioned this now, as I first recall, over a year ago, that we needed to take a look at catastrophic illness and how we might help senior citizens, particularly, deal with it when it occurs. Am I right in terms of this being something that he first mentioned over a year ago?

Dr. **Bowen**. The President, in his State of the Union address—I believe it was in February of last year—charged me with the responsibility of finding ways for the private and public sectors to work together to solve the problem for catastrophic illness expenses for all age groups.

Senator **Riegle**. And when did you start with your study?

Dr. **Bowen**. Oh, we began almost immediately after we received that charge. I suspect we have been going at it for nine months now.

Senator **Riegle**. Nine months?

Dr. **Bowen**. Yes.

Senator **Riegle**. And when did the group that has undertaken this effort finish its work?

Dr. **Bowen**. I believe the report was issued sometime in November.

Senator **Riegle**. In November?

Dr. **Bowen**. Yes.

Senator **Riegle**. So, it has been available since November. We are now at the end of January. I take it that this has really touched off something of a firestorm within the Cabinet. This is the view one gets, because you have been asked to do the study, you have made the recommendations, it is clear-cut, but the President hasn't endorsed it.

I am troubled about that, because it seems to me that you are the chosen person to lead this effort—you have done it, you have developed a proposal, you brought it forward after a year's effort. But unfortunately, there is no recommendation from the President. You are not able to bring one in today. And I gather that there is some sort of struggle going on, where somebody must not like what you have brought in.

Dr. **Bowen**. Let me state that the President is not insensitive to the problem. If he were, he would not have asked us to do the study. And I know that he is agonizing over the approach to it. I also know that it is the desire of the Administration, as it is mine, to keep as much of it as possible in the private sector.

The part that has caused the most controversy is that which is really the smallest part of the whole issue, and that is acute care for the elderly; our report does advocate an expansion of the coverage for Medicare beneficiaries through an added premium to Part B.

Senator **Riegle**. But obviously you have a personal background in medicine, and so you are a person who brings some very particular knowledge to this. And after all of those months of study, for you to make that recommendation says to me that you felt that was an urgent problem, and that that is clearly the best way to solve it. Shouldn't I read that into the fact that that was the recommendation that you and your group reached?

Dr. **Bowen**. Yes, and we have so stated in our report. But we also studied some 50 different options, many of which are included here. Our preferred option is our opinion, and if others don't agree with it, well, that's fine, too. But I have stated many, many times that, even if our suggestions are not followed, the very fact that the important subject has been elevated to the level it has, and that it is receiving good debate and discussion, indicates that something good will follow from it; my feelings are not going to be hurt as long as something good comes from it.

Senator **Riegle**. Well, I would agree with you on that. The problem is that sensitivity about the problem doesn't mean much if we don't do something. And that is why you have worked so hard on it, you have made the recommendation.

I guess I am a little troubled about where we stand right now, because I saw you last evening when we sat not many seats apart on the floor of the House to listen to the President with the State of the Union message. He is concerned about education, and we have a budget proposal to cut the money for education. He is concerned about the drug problem, and we have a proposal to cut the amount of money to carry out the drug program that we just enacted, just a few months ago. And there is a sensitivity and a concern about this problem, but there is no recommendation.

I don't hold you at fault for that, because you have obviously done your work; but it looks to me that the Administration, for whatever the reason, either can't make up its mind, or won't make up its mind.

I mean, we are here today, all of us, to try to move this thing ahead, and I guess that what you have to say to us is that while you have an opinion as the Cabinet Officer in charge, the Administration has no opinion at the moment, that it is still trying to make up its mind and therefore doesn't have a proposal to make to us at the present time.

Dr. Bowen. The final decision, as I read into the supplemental report the President issued, will be forthcoming shortly.

Senator Riegle. Any idea when? I know my time is up, but do you have any idea?

Dr. Bowen. No, I can't give you any timetable.

Senator Riegle. Do you think it is likely to be weeks? Or is it months?

Dr. Bowen. No. I would think, when the President says, "Soon," that would be soon, and that would be within a few weeks.

Senator Riegle. But I gather you don't know precisely yourself when we are going to get a final answer here.

Dr. Bowen. No, I don't.

Senator Riegle. I thank you.

The Chairman. Thank you very much, Senator Riegle.

Dr. Bowen, figuring reimbursement for Medicare based on a prospective basis, on DRG's, there is a great incentive for hospitals to discharge patients, perhaps sicker than they were under the previous system, and an increased demand for home health care and community based services, more than ever before. Yet, at the same time we see the General Accounting Office charging the agency or charging the Department for the laxity in practices of reimbursement for home health services. And we have seen one of the major health trade associations talking about issuing a call for mandatory standards to improve the quality of training for home health care services for the personnel involved.

So, as a part of overall effort to improve transitional care from the hospital to the home, should we address the question of home health care services? Do you have any specific suggestions for this committee in that regard?

Dr. Bowen. I don't think I have any specific ones today, but I want to assure you that quality of care, irrespective of where it is given, is one of our chief aims. The need for an increased amount of home care—again, providing the quality can be retained—would be a move in the right direction.

The Chairman. I recall Senator Heinz and I sponsored legislation to try to further address the intermittent health care problems, and we finally lost that one in conference. It is an area that I still think has not been resolved and needs to be addressed.

Dr. Bowen. Dr. Roper, the Administrator of HCFA, and I have been intensely interested in this subject, in really defining "quality of care" in the various areas where care is given. We have already had one conference on that topic with all of the health care industry. We are all working hard to define what we mean and expect from the term "quality of care" and how to judge it. That is the problem, how do you measure it? Right now the only method we have is mortality and morbidity statistics. And from mortality statistics, we can show that we don't think quality has deteriorated, at least from that standpoint.

The CHAIRMAN. Doctor, I know the other commitments you have, but I would now defer to Senator Durenberger for any questions that he might have.

Senator DURENBERGER. Thank you, Mr. Chairman.

Obviously we all have questions, but I respect your time and the Secretary's. I understood that maybe we were waiting on Senator Baucus; and, if so, I would be glad to ask some questions. If we are not, we can withhold my questions.

The CHAIRMAN. We will let those gentlemen—there are others who are not here but have questions—submit them for the record if they are not here by the time you finish speaking.

Senator DURENBERGER. All right. If I might, then, I have just one or two questions for the Secretary. And if I may go back to the principles area where we were before, since we are not going to agree today on what kind of a program the Administration is going to send up, maybe we can get some idea of some of the principles that are involved.

My last question to you, Mr. Secretary, was on the issue of overutilization. If we make it possible for everyone in America to spend $2000 a year out of their pocket and then get free health care after that—and this is an exaggerated theory of catastrophic—a lot of people are going to stand up and say, 'Hey, we can't afford to do that.'

Your response to that question was that we have in place and are putting in place—and you repeated it a couple of times—utilization control of one kind of another, and that includes peer review and some other.

I would like, maybe for the record, for you to talk to us a little bit about case management in the Medicare System, also. In other words, where do you think we should be headed in terms of a system helping people to decide how much of what kind of health care provisions they have to get.

But let me get to another important principle that is sort of a political principle, and for me it is a generational principle which is terribly important as we go about reforming Medicare: I would like to see us expand the benefits of the basic Medicare program, but I would also like to see us continue to privatize this health insurance system. And I think you agree with that, because that is the Administration's philosophy and your own.

Tomorrow I think we are going to have the subcommittee hearing where we talk about where Medicare is at, and I hope at that time we hear about PHPO, the Private Health Plan Option, so that maybe Beryl Sprinkle and Ed Meese and all of those guys could tune in and find out that their own administration is privatizing the Medicare system, and all you are suggesting we do is add a very important benefit to this private health plan over which all of these insurance companies fight to sell to the elderly.

Now let me get to the principal point of the question, and that is: Who should pay for catastrophic?

If you set up an ideal catastrophic now, as you have suggested, you are putting the payment for acute care catastrophic into a premium, meaning all beneficiaries 65 and over and disabled, and so forth, will pay for the catastrophic out of an annual or a monthly fee.

There are other ways to do that, which would combine a premium and some cost-sharing for utilization. You could say for each day in the hospital you will pay 10 percent of the cost. Or you could do it with a deductible, or some combination thereof.

Let me ask you, is it a principle to you, and do you think to this Administration, that the benefitting generation or the beneficiaries should pay for added benefits like catastrophic, or should we have them pay part of it and let their children, in the form of a payroll tax, or their children in the form of a general tax such as we use for Part B, pay for these benefits?

I think you can see the significance of that question. It would help us a great deal as we try to design what people my parents' age really need.

Dr. **Bowen**. In my personal judgment, I am a "pay-as-you-go" man, and I think that is the best way to proceed rather than to have an intergenerational transfer of the responsibility.

Senator **Durenberger**. Well, we already do a certain amount of that, obviously. We have—what?—two and a half percent of my payroll, or in fact 5 percent of payroll, that is going to pay already for my parents' access to Medicare. What you are saying is, if we add more benefits, those benefits ought to be paid for by the benefitting generation.

Would you say that that might be particularly true, and maybe the record can show us why, because the savings—the 65 percent of American elderly today who are out there responding to every over-65 movie actor other than the President trying to sell them catastrophic insurance—the savings from not taking their fears and buying into this stuff that is being sold out there, could be used for premiums, and, something else, the savings could go right into their pockets?

Dr. **Bowen**. Yes. But again, you are working against private industry, so to speak; but private industry should be regulated to the point that what they are selling is fair to the purchaser.

I don't know if I can give you, the exact figures of those who have multiple policies that are overlapping and that are unnecessary, some of which go as high as $1000 or $1200 a year, but that is the exception. I don't want to exaggerate here. Some of the policies are absolutely good and do the job that they are supposed to.

Again, I want to compliment Senator Baucus, because the amendment that he sponsored has made that industry much more responsible and better. And I appreciate that.

The **Chairman**. Senator Baucus, I think with that kind of an entre, you can start questioning.

Senator **Baucus**. Thank you, Mr. Chairman, and thank you, Mr. Secretary.

I recall that the 1980 amendment asked the Department to evaluate the program and to make recommendations as to how the program can be improved, if indeed improvements are necessary. I say that because I understand that earlier today Senator Pryor asked about the amendments, and you, Mr. Secretary, responded that there is a problem involved, namely that states are not required to take any action until they find that the premiums are overpaid compared with a fair return on the policy.

I wonder, do you have any off-the-top-of-your-head views as to how we can improve upon those amendments so that there are some teeth involved? Or, second, if you are not able to do so now, whether the Department in fact, as required in those 1980 amendments, will send up to us the Department's recommendations for improvements?

Dr. BOWEN. It is my understanding that the regulations are administered primarily by the states. The insurance companies report to the state insurance commissioners what their anticipated payouts are going to be, but they don't necessarily end up being what they anticipate. There is no follow-up on that as to whether they could have met the required amount or not.

So, working with the insurance commissioners of the states to correct that so that there would be a little more checking on insurance companies' reports—that probably would make it more effective, but, again, you would have 50 people to deal with on this issue.

Senator BAUCUS. I hope to see the Department's recommendations, because I think that would be very helpful, since you have some experience here.

Second, can you tell us what "shortly" means, when the President last night said he would be sending up catastrophic insurance to The Hill shortly? When can we expect to see that recommendation?

Dr. BOWEN. I honestly cannot answer it. "Shortly," to me, is a very few weeks at the most. But I cannot answer that question.

Senator BAUCUS. Can you tell us here today whether any of the options that the President was talking about a year ago in this general area have been ruled out? Because last night it sounded like he was suggesting catastrophic insurance only for the elderly and not for any other groups; although, a year ago he spoke generally and suggested that we should address the general question of catastrophic insurance.

Have any of the options that the Administration has been looking at been ruled out?

Dr. BOWEN. Not to my knowledge. We were given the charge in our study to find ways to work with the private sector, whereby catastrophic illness expenses could be met by all age groups and under all settings, whether it be acute care for the elderly, whether it be long-term care for the elderly, or whether it be for those up to 65 years of age.

Senator BAUCUS. So, none of those have been ruled out?

Dr. BOWEN. Not to my knowledge.

Senator BAUCUS. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Baucus.

Dr. Bowen, I think it is obvious that there is a great interest and concern in this area, and that there is not a consensus at this point on this committee and maybe not even in the Admioistration. But we will achieve one, and I am confident that we will have legislation coming out of this committee, and that it will be productive legislation, substantive legislation. And you have made a major contribution to it. We are most appreciative of your being here. Thank you.

Dr. Bowen. Thank you, sir.

[Whereupon, at 12:13 p.m., the hearing was concluded.]

[By direction of the chairman the following communication was made a part of the hearing record:]

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THE AMERICAN JOURNAL
OF GASTROENTEROLOGY

Statement of

Edwin M. Cohn, M.D., FACG
National Affairs Chairman
of the
American Collge of Gastroenterology

before the

Committee on Finance
United States Senate

concerning

Catastrophic Health Insurance

January 28, 1987

Annual Scientific Meeting and Postgraduate Course
October 15-19, 1986, Atlanta Hilton Hotel, Atlanta, Georgia

Mr. Chairman and Members of the Committee, on behalf of the American College of Gastroenterology, I wish to thank you for holding this important hearing. The time for us, as a nation, to address the problem of inadequate health care coverage is long overdue.

Today, approximately 30 million elderly Americans are exposed to financial hardship due to a catastrophic illness or long-term care need. Gastroenterologists see these patients on a daily basis. These individuals, most of whom have worked hard all their lives, should not be asked to surrender their life's savings because they have a serious or severe illness. The American College of Gastroenterology believes that something can and must be done to prevent the financial devastation that American families are enduring solely because one family member has a catastrophic illness or need for long-term care services.

ACG also believes that HHS Secretary Bowen's proposal is a step in the right direction. In addition to providing a mechanism for catastrophic illness coverage under Medicare, the Secretary's proposal is important for two reasons - One, it recognizes that the problem exists and should be remedied. Second, it perceives the Federal Government as having an important and necessary role in the process while remaining budget neutral.

However, the Secretary's plan does not go far enough and could be improved. It does not cover long-term care needs, nor does it cover the cost of drugs, as well as other costs; for instance, such as those for vision and hearing problems. Clearly, the Administration's proposal will need to be supplemented in order to best meet the needs of the American people. Nevertheless, Secretary Bowen should be congratulated for his valiant efforts to address this problem.

Mr. Chairman, much is being said these days about health insurance coverage for catastrophic illness, and as you know, numerous Committee and Subcommittee hearings are being held on this issue. ACG perceives this current debate as positive in that it has drawn attention to the severe consequences of the problem. Our major concern is that without passage of Congressional legislation, these discussions will remain mere rhetoric. The American College of Gastroenterology recommends that Congress move swiftly and thoughtfully to enact Federal legislation to provide Medicare coverage for catastrophic illness and long-term care.

Thank you for the opportunity to present our views. The American College of Gastroenterology is happy to assist you in any way Members deem appropriate.

TESTIMONY OF THE
AMERICAN ACADEMY OF FAMILY PHYSICIANS

The American Academy of Family Physicians is the national medical specialty organization representing more than 59,000 family physicians, medical students and family practice residents.

We are pleased to have the opportunity to address a problem of mutual concern to members of this committee and to family physicians throughout the country--the need for access to catastrophic health coverage for all Americans. We commend the members of this committee for the thorough review that you are giving this subject.

At the outset, we do want to point out that catastrophic initiatives are of limited good in achieving increased access to health care, because they are oriented toward coverage of hospital care, and not preventive or maintenance care, or long term care. However, the Academy views the effort in Congress to address catastrophic coverage as a positive step toward the eventual assurance of access to appropriate health care for all Americans.

Family physicians see, first hand, the need for protection from catastrophic health care costs. We share with our patients and their families the fear of financial devastation that can result from serious illness or injury. In our offices we are caring for patients who require an increased intensity of services because they are discharged from the hospital earlier--and sicker. Many of these services are not adequately covered by Medicare. We struggle with the dilemma of our elderly patients whose families are not able to care for them at home, but who cannot afford nursing home care. We see families forced into poverty by health care expenses before meeting Medicaid eligibility criteria for nursing home care. And although we may not see them, we know there are many patients who opt to go without needed care because of gaps in Medicare coverage.

Catastrophic medical events pose a financial threat to Americans of all ages and therefore the need for catastrophic coverage is not limited to acute care for the Medicare population. Rather, the need encompasses the acute care expenses of the elderly, long term care expenses, and catastrophic coverage of the general population. The American Academy of Family Physicians has considered the issue of catastrophic coverage from this broad perspective and has considered various options to address each of these areas of need. We look forward to working with you to address catastrophic coverage in a comprehensive fashion.

Current Medicare Acute Care Coverage

The financial liability of the Medicare beneficiary for acute care can become quite substantial under the current system as there is no upper limit on the out of pocket expenses the elderly may pay for services.

Currently under Medicare Part A the beneficiary must pay $520 for the first day of hospitalization. The amount serves as the deductible. Then for days 2-60 of a single spell of illness Medicare covers the inpatient care without charging the beneficiary. However, the beneficiary liability increases to $130 per day for days 61-90, and for days over 90 (which are taken from the 60 days of lifetime reserve) the beneficiary copayment is $260 per day.

Under Part B the annual deductible per beneficiary is $75.00. Part B covers 80% of what Medicare determines is a reasonable charge for physicians services, with the beneficiary liable for the 20% copayment, plus any additional amount charged by the physicians. Neither routine physician services nor outpatient prescription drugs are covered by Medicare.

Proposals For Catastrophic Coverage of Acute Care

Proposals have been introduced in Congress which would go a long way toward limiting out of pocket medical expenses. We commend the Members of Congress who have thoughtfully contributed to the current debate on catastrophic health care insurance. Most discussed are proposals based on the plan developed by HHS Secretary Otis Bowen, S.592, S.754 and H.R. 1245, and proposals introduced by Representatives Stark and Gradison, H.R. 1280 and H.R. 1281. The AAFP supports provisions in these proposals to eliminate coinsurance for hospital stays and provide unlimited hospital days after the required deductible is met. Another good feature in both would improve the skilled nursing home benefit by reducing beneficiaries' coinsurance liability.

The Stark-Gradison approach provides a slightly more comprehensive total benefit package than the Bowen proposals and is also more costly. Other plans are being discussed with more benefits which also add to the cost of the program. The feasibility, administrative simplicity and wide support of the Bowen plan, however, are extremely attractive features. We believe these are important features which make it possible to enact this proposal as soon as possible.

Financing of Acute Coverage

While the need for catastrophic health care coverage is clear, the strategy for providing access to such coverage is not. The ability to finance a catastrophic program in fact defines the scope of the coverage that can be provided. The American Academy of Family Physicians encourages Congress to balance fiscal responsibility with compassion for the elderly in evaluating proposals for catastrophic coverage.

Catastrophic coverage of acute care expenses of the elderly should be accomplished through restructuring of the Medicare program. Such a restructuring should limit the financial liability of the beneficiary for acute care, and cover an unlimited number of days of acute hospital care. A responsible approach to providing this type of Medicare coverage would be to have Medicare beneficiaries share the catastrophic risk through payment of an actuarily sound additional premium. As outlined in S.592, this approach would provide a $2000 annual limit for out of pocket expenses for Medicare covered services, a limit which would be affordable for nearly all beneficiaries. While a lower out of pocket limit than $2000 annually may be desirable, we are concerned that the additional premium that would be required to finance the catastrophic program would prove too costly to low income elderly. In this event subsidized purchase of the catastrophic policy for low income individuals, perhaps through a voucher or a tax credit, might be necessary.

Other proposals, H.R. 1280 and H.R. 1281, would finance the catastrophic benefit by taxing a portion of the benefit's actuarial value. Approximately 35% of the elderly with the highest incomes would be taxed under this strategy. It would avoid imposing additional financial burdens on low income elderly and additional taxes on current workers. However, should program costs increase more rapidly than projected or as additional benefits are added, the increased cost to middle and higher income beneficiaries could become a financial strain.

CATASTROPHIC COVERAGE OF CHRONIC OR LONG TERM CARE

Protecting the population from the costs of long term care for the chronically ill also should be addressed by Congress.

According to the AARP, nursing home stays account for over 80% of the expenses incurred by older people spending over $2000 per year out of pocket for health care. With Medicare and private insurance paying an estimated 3% of nursing home costs, Medicaid is the only alternative available to many of the nation's elderly. Life savings and assets are depleted to pay for nursing home care before Medicaid eligibility requirements are met. Spouses are left impoverished in order that their partners receive the care that they need. Family physicians are keenly aware of the impact of long term care expenses on their patients, their spouses and their families.

Solutions for providing protection from the catastrophic expenses of long term care are more difficult to develop than other components of catastrophic health coverage. The AAFP believes that the combined efforts of the government and the private sector are needed to address this problem. Steps taken immediately to protect some of the population at risk may stimulate other initiatives which will cover a broader population.

In the Congressional Record of March 17, Senator Chafee notes that "approximately one-half of all Medicare recipients in nursing homes were not initially poor, but spent their income and resources on long term care before becoming eligible for Medicaid." The AAFP believes that a variety of strategies for addressing long term care should be considered. This organization supports the following Bowen report recommendations:

*the federal government work with the private sector to educate the public about the risks, costs, and financing options available for long term care, as well as the limitation of coverage for such services under Medicare and Medigap supplemental insurance.

*that the federal government encourage personal savings for long term care through a tax favored Individual Medical Account (IMA) combined with insurance, and amend Individual Retirement Accounts (IRA) provisions to permit tax-free withdrawal of funds for any long term care expense.

*encouraging development of the private market for long term care insurance by establishing a refundable tax credit for long term care insurance premiums, providing favorable tax treatment for long term care insurance reserves and removing barriers to prefunding long term care benefits provided by employers to retirees.

*offering employee-paid long term care group insurance as an option under the Federal Employees Health Benefit Program.

Other options for financing long term care which should be explored include state home equity conversion programs, which would provide additional liquidity for house-rich/cash-poor persons to pay for long term care without being forced to sell their homes, and capitated delivery systems, such as HMOs, to spread the risk.

The Academy believes that Congress must consider means of addressing the costs of long term care in its discussions of catastrophic coverage, costs which are the major concern of the population. We believe the above options, which have been endorsed by the American Academy of Family Physicians should be given serious consideration.

Medigap

An estimated 70 percent of the Medicare population purchases Medigap policies to supplement what Medicare pays. The elderly often don't understand what the gaps in Medicare coverage really are, and purchase plans which are not adequate or which do not cover preexisting conditions. Some purchase multiple plans out of the fear of financial ruin that a long illness can bring only to find that the plans do not cover their medical care. The Academy would recommend that the federal government mount an intensive information campaign to improve public understanding of Medicare and Medigap coverage limitations. This is particularly important in the area of long term care. Much of the public is unaware that Medicare does not cover long term care and that most Medigap policies are structured to address gaps in acute care coverage, not long term care needs.

We are concerned that if Congress enacts an acute care catastrophic benefit the public must be fully informed of the limitations of Medicare coverage which will still exist. Beneficiaries will continue to assume financial risk for uncovered service, various deductibles and coinsurance.

Conclusion

This year there is the momentum in Congress to enact legislation to fill some of the gaps in Medicare coverage. The American Academy of Family Physicians urges Congress to seize the opportunity to take this important first step toward the provision of comprehensive catastrophic health coverage for the American public.

Thank you for the opportunity to appear before you today. I would be pleased to answer your questions.

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